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ABSTRACT

This resource guide reflects, largely through statistical information, the status of health care in rural New York State. It is divided into five sections: (1) Demographics, Socioeconomics, and Technology; (2) Client Needs; (3) Provider Needs; (4) Designing an Integrated Rural Health System; and (5) Developing a Rural Health System for New York State. The first section offers information on the state's population, employment, and income distributions across six types of counties categorized by the extent of urbanization from metropolitan to limited urban influence. The second section gives statistics on birth, health, and infant and other mortality rates, as well as information on health payment sources. The third section looks at availability of services, reimbursement, the education and training of health care personnel, and rural health networking. The fourth section examines the goals and criteria for designing an integrated state health system that includes both client services and the components that link them. The fifth section further discusses the mechanisms, tools, policies, and strategies for implementing a rural health framework and its components. Four appendices use national data to examine the following topics: (1) selected U.S. facts of interest to rural health; (2) rural health system components in other states; (3) system development alternatives in other states; and (4) emerging rural health system components in New York State. This document also includes a subject index and a bibliography of 40 entries. (TES)

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Rural Health Resource Guide

A Compilation of Data and Information On Rural Health in New York State

State of New York Legislative Commission on Rural Resources

Volume I

Prepared For:
A Legislative Symposium on Rural Health Care
Bassett Hospital Conference Center
Cooperstown, New York
April 29 — May 1, 1987

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New York State Legislative Commission on Rural Resources
August 1987

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The legislature hereby finds and declares that the economic and social well-being of the people of the state is clearly related to the state's rural resources. The rural economy and environment contribute greatly to the quality and maintenance of life in New York State. Rural areas offer an important alternative to urban living. New York's indispensible rural resources are decentralized, diverse and unique, and their enhancement and protection require special attention in view of their special characterization and needs.

A legislative commission on the development of rural resources is hereby established (1) to examine the impact of rural resources upon the state's economy; (2) to review existing laws and regulations as they pertain to rural resources; (3) to assess the effectiveness of programs specifically addressed to rural resource needs and problems; (5) to make such recommendations to the legislature for action as it determines necessary for the enhancement and protection of the state's rural resources.

Excerpted from:
Chapter 428 of the Laws of the State of New York, May 13, 1982, creating the Legislative Commission on Rural Resources

Where there is no vision, the people perish.

Proverbs 29:18 KJV

RURAL HEALTH RESOURCE GUIDE

A Compilation of Data and Information
on Rural Health in New York State

August 1987

State of New York
Legislative Commission on Rural Resources

Legislative Office Building
Albany, New York 12247
(518) 455-2544

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To The Readers of this Resource Guide:

A preliminary version of this Resource Guide was originally prepared for the participants of the second Legislative Symposium on Rural Health, which was sponsored by the Commission on Rural Resources on April 29 - May 1, 1987 at The Mary Imogene Bassett Hospital Conference Center in Cooperstown, New York. The data and information contained in the resource guide address many of the major issues discussed by symposium participants in their endeavor to build a rural health services system for the next two decades. The results of the work undertaken by symposium participants are contained in a separate report.

The Resource Guide provides in-depth background material for the recommendations set forth in the conference report, as well as documentation regarding the needs and issues symposium participants addressed. As such, the Resource Guide reflects as accurately as possible the current status of health care in rural New York.

It is expected this document will be revised and expanded periodically as a source of timely and useful information. Thus, the Resource Guide can be viewed as a snapshot of health care in rural New York, that hopefully will provoke further discussion and research. Suggestions regarding the content of this document and ways to improve it are welcomed.

The preparation of the Guide could not have been accomplished without a great deal of assistance by many individuals and organizations. The Symposium Steering Committee members were especially helpful, not only in planning the conference but also in guiding the development of the report. In addition, the staffs of the State Health Department, state legislative offices, and regional health systems agencies were particularly helpful in providing information and data on the status of health care in rural New York.

We are also grateful to officials in other states and to such agencies as the National Rural Health Association, the Hospital Association of America, and Age-Wave, Inc. who gave us the benefit of their experience in health care. In the appendix to this guide we have included a broad range of case studies and legislative initiatives from other states they have brought to our attention. These have proven to be very thought-provoking and hopefully will be of interest to other people as well.

Senator Charles D. Cook
Chairman
NYS Legislative Commission
on Rural Resources

DEMOGRAPHICS, SOCIOECONOMICS, TECHNOLOGY

- Population
  - Population Density
  - Population Change

- Employment
  - Unemployed
  - Self-employed

- Income
  - Median Family Income
  - Families in Poverty
  - Families in Affluence

- Technology

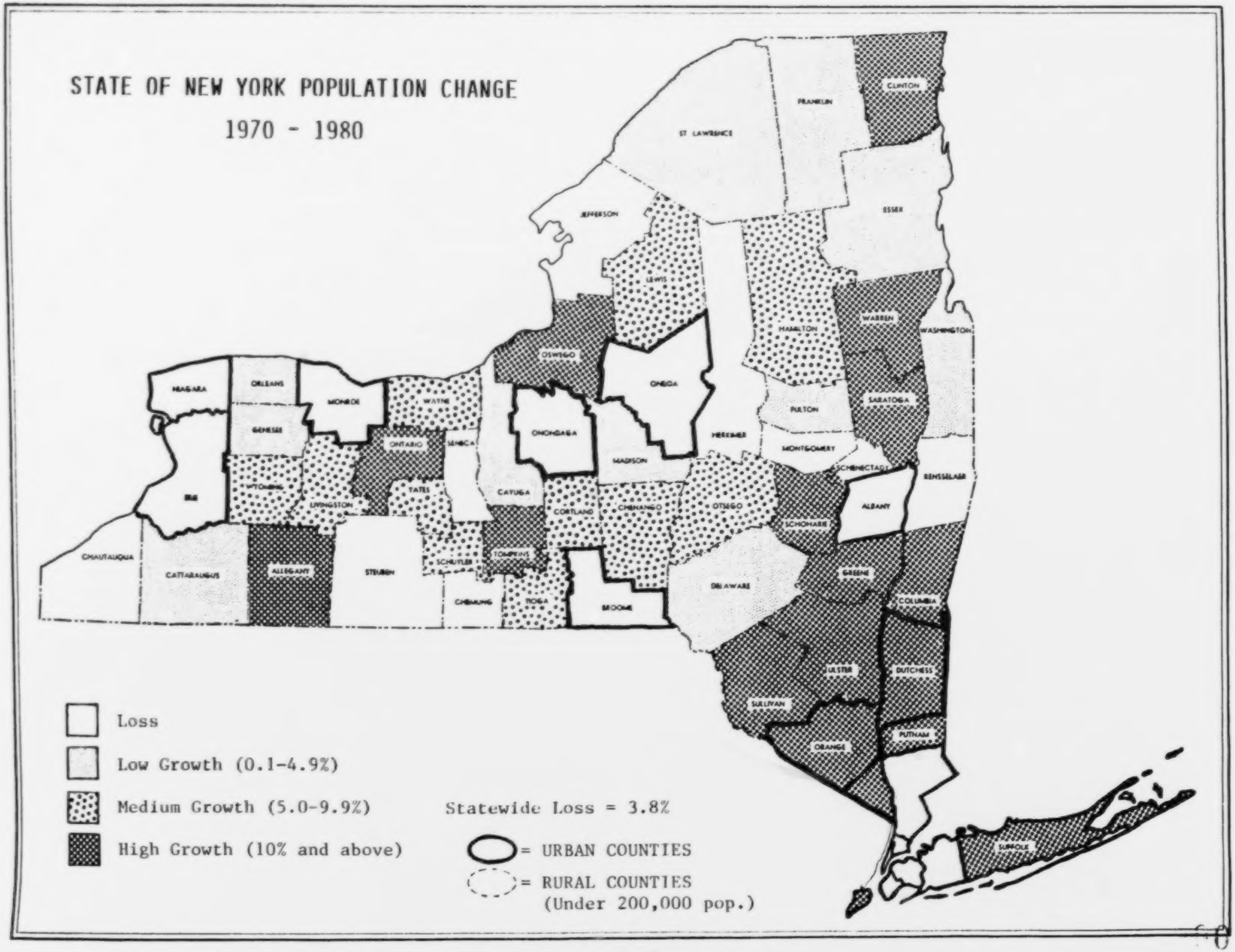
RURAL NEW YORK'S POPULATION RANKED WITH ALL STATE POPULATIONS, 1980

Rank	Total Population	State
1	23,667,902	California
2	17,558,072	New York
3	14,229,191	Texas
4	11,863,895	Pennsylvania
5	11,426,518	Illinois
6	10,797,630	Ohio
7	9,746,324	Florida
8	9,262,078	Michigan
9	7,364,823	New Jersey
10	5,881,766	North Carolina
11	5,737,037	Massachusetts
12	5,490,224	Indiana
13	5,463,105	Georgia
14	5,346,618	Virginia
15	4,916,686	Missouri
16	4,705,767	Wisconsin
17	4,591,120	Tennessee
18	4,216,975	Maryland
19	4,205,900	Louisiana
20	4,132,158	Washington
21	4,075,970	Minnesota
22	3,893,888	Alabama
23	3,660,777	Kentucky
24	3,121,820	South Carolina
25	3,107,576	Connecticut
	3,088,546	**RURAL NEW YORK**
26	3,025,290	Oklahoma
27	2,913,808	Iowa
28	2,889,964	Colorado
29	2,718,215	Arizona
30	2,633,105	Oregon
31	2,520,638	Mississippi
32	2,363,679	Kansas
33	2,286,435	Arkansas
34	1,949,644	West Virginia
35	1,569,825	Nebraska
36	1,461,037	Utah
37	1,302,894	New Mexico
38	1,124,660	Maine
39	964,691	Hawaii
40	947,154	Rhode Island
41	943,935	Idaho
42	920,610	New Hampshire
43	800,493	Nevada
44	786,690	Montana
45	690,766	South Dakota
46	652,717	North Dakota
47	594,338	Delaware
48	511,456	Vermont
49	469,557	Wyoming
50	401,851	Alaska

Source: 1980 Census of the Population, U.S. Bureau of the Census.

STATE OF NEW YORK POPULATION CHANGE

1970 - 1980


ST LAWRENCE
FRANKLIN
CLINTON
ESSEX
JEFFERSON
LEWIS
HAMILTON
WARREN
WASHINGTON
OSWEGO
ONEIDA
HERKIMER
FULTON
SARATOGA
MONTGOMERY
SCHENECTADY
RENSSELAER
ALBANY
NIAGARA
ORLEANS
MONROE
WAYNE
GENESEE
ONTARIO
SENECA
ONONDAGA
MADISON
CAYUGA
ERIE
WYOMING
LIVINGSTON
YATES
CORTLAND
CHENANGO
OTSEGO
SCHOHARIE
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN
SCHUYLER
TOMPKINS
CHEMUNG
TIOGA
BROOME
DELAWARE
GREENE
COLUMBIA
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
SUFFOLK
Loss
Low Growth (0.1-4.9%)
Medium Growth (5.0-9.9%)
High Growth (10% and above)
Statewide Loss = 3.8%
= URBAN COUNTIES
= RURAL COUNTIES (Under 200,000 pop.)

Source: U.S. Bureau of the Census, 1980 Census of Population and Housing.

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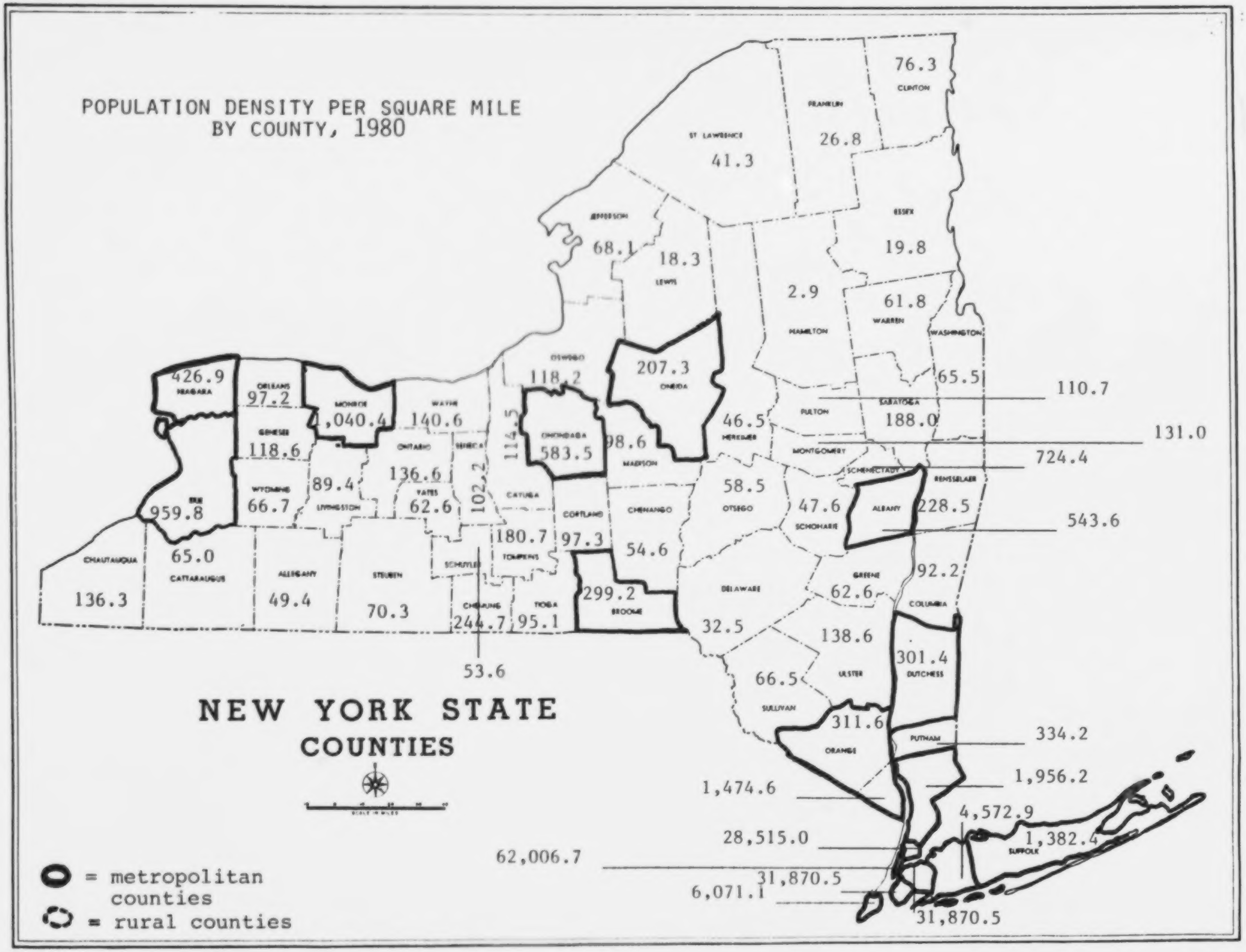

POPULATION DENSITY PER SQUARE MILE
BY COUNTY, 1980

NEW YORK STATE
COUNTIES

76.3
CLINTON
FRANKLIN
26.8
ST. LAWRENCE
41.3
ESSEX
19.8
JEFFERSON
68.1
18.3
LEWIS
2.9
HAMILTON
61.8
WARREN
WASHINGTON
65.5
110.7
OSWEGO
118.2
207.3
ONEIDA
426.9
NIAGARA
ORLEANS
97.2
MONROE
1,040.4
WAYNE
140.6
FULTON
SARATOGA
188.0
131.0
46.5
HERKIMER
MONTGOMERY
724.4
GENESEE
118.6
ONTARIO
SENECA
114.5
ONONDAGA
583.5
98.6
MADISON
SCHENECTADY
RENSSELAER
136.6
102.2
89.4
WYOMING
66.7
LIVINGSTON
YATES
62.6
CAYUGA
CORTLAND
CHENANGO
58.5
OTSEGO
47.6
SCHOHARIE
ALBANY
228.5
543.6
ERIE
959.8
180.7
TOMPKINS
97.3
54.6
65.0
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN
SCHUYLER
299.2
BROOME
DELAWARE
GREENE
62.6
92.2
COLUMBIA
136.3
49.4
70.3
CHEMUNG
244.7
TIOGA
95.1
32.5
53.6
138.6
301.4
DUTCHESS
66.5
ULSTER
SULLIVAN
311.6
ORANGE
PUTNAM
334.2
1,956.2
1,474.6
4,572.9
1,382.4
SUFFOLK
28,515.0
62,006.7
31,870.5
6,071.1
31,870.5
SCALE IN MILES

= metropolitan counties

= rural counties

CLASSIFICATION OF COUNTY TYPES*

In his analysis, Socioeconomic Trends in Rural New York State: Toward the 21st Century (September 1984), Professor Paul R. Eberts of Cornell University devised a classification scheme for all counties in the state. By using a set of population and socioeconomic variables, Eberts formed six categories of county types, with the following basic characteristics:

Type 1:	Downstate Metropolitan
Type 2:	Upstate Metropolitan
Type 3:	Rural With Extensive Urban Influence
Type 4:	Rural With Considerable Urban Influence
Type 5:	Rural With Moderate Urban Influence
Type 6:	Rural With Limited Urban Influence

The counties in each category are demonstrated in the following chart:

EBERTS URBAN/RURAL TYPOLOGY FOR NYS COUNTIES

TYPE 1	TYPE 2	TYPE 3	TYPE 4	TYPE 5	TYPE 6
Bronx	Albany	Cayuga	Cattaraugus	Columbia	Allegany
Kings	Broome	Fulton	Chautauqua	Greene	Chenango
Nassau	Dutchess	Genesee	Chemung	Hamilton	Delaware
New York	Erie	Madison	Clinton	Herkimer	Essex
Queens	Monroe	Montgomery	Cortland	Livingston	Franklin
Richmond	Niagara	Ontario	Jefferson	Orleans	Lewis
Rockland	Oneida	Oswego	Otsego	Putnam	Sullivan
Suffolk	Onondaga	Rensselaer	St. Lawrence	Schoharie	
Westchester	Orange	Saratoga	Steuben	Schuyler	
		Schenectady	Tompkins	Seneca	
		Wayne	Ulster	Tioga	
			Warren	Washington	
				Wyoming	
				Yates	

This classification scheme is used for most of the statistical tables and graphs in this Resource Guide.

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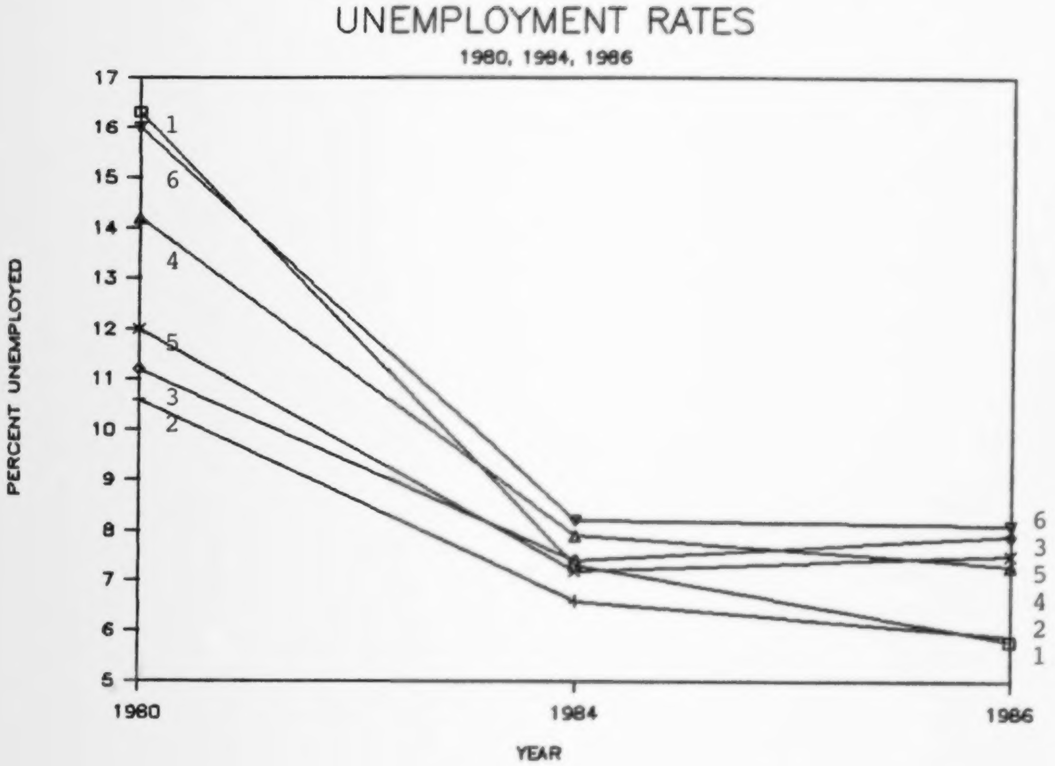
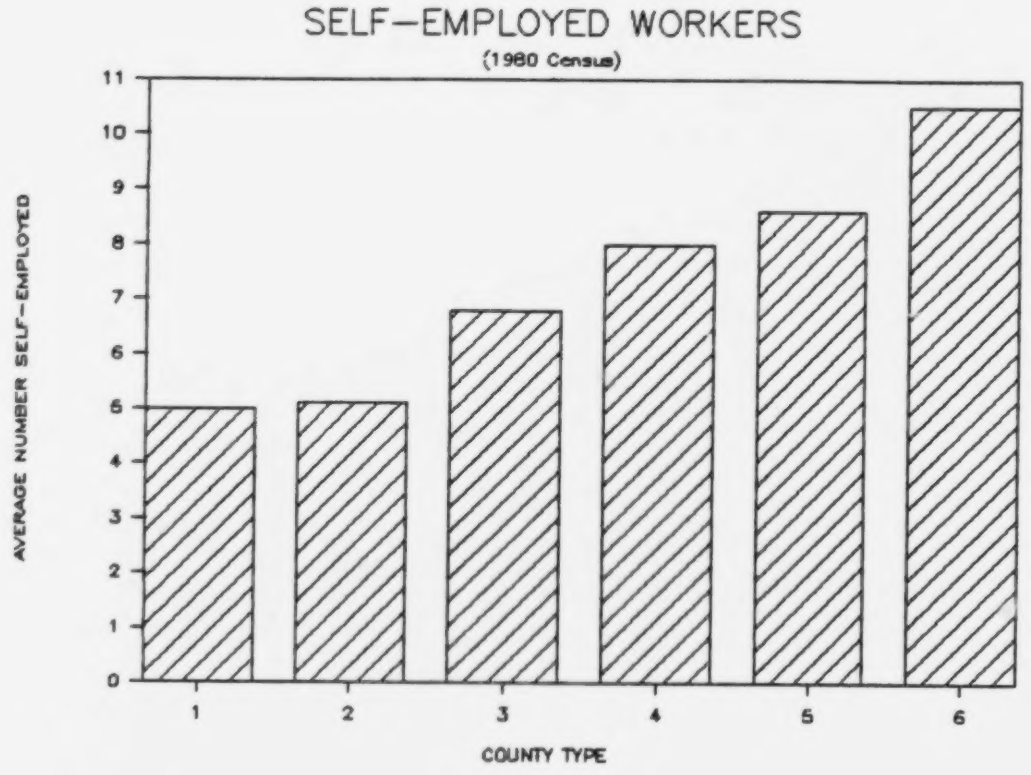
* See pp. 99-112 for a more detailed discussion of methods of defining "rural."



County Type		1980	1984	1986
Metro	1	16.3	7.3	5.8
	2	10.6	6.6	5.9
Rural	3	11.2	7.4	7.9
	4	14.2	7.9	7.3
	5	12.0	7.2	7.5
	6	16.0	8.2	8.1

The period 1980 to 1984 saw drastic reductions in unemployment rates statewide. However, since 1984 the metropolitan counties' unemployment rates continued to decline, while rates for all four rural county types stabilized. Thus, the current rates of unemployment are much lower overall for metropolitan counties than for rural counties.

Source: New York State Department of Labor



The percentage of employed persons who were self-employed in 1980 was almost twice as high for the vastly rural counties (Types 5 & 6) as for the metropolitan counties (Types 1 & 2).

Since many self-employed workers must provide their own health insurance (and the rates for individual coverage are greater than for group coverage), the urban/rural percentage difference is significant.

Source: U.S. Census Bureau, 1982

MEDIAN FAMILY INCOME

	COUNTY TYPE	1950	1960	1970	1980
	1	$3,665	$6,569	$ 10,901	$ 20,344
METRO	2	3,506	6,519	10,908	21,405
RURAL	3	3,240	5,779	9,993	19,513
	4	2,965	5,525	9,049	17,428
	5	2.798	5,432	9,622	18,917
	6	2,612	4,955	8,516	16,007

PERCENTAGE OF FAMILIES IN POVERTY

	COUNTY TYPE	1950	1960	1970	1980
	1	18.4%	13.2%	12.8 %	16.3 %
METRO	2	17.5	12.3	10.0	10.6
RURAL	3	22.6	16.7	11.1	11.2
	4	27.7	18.6	14.0	14.2
	5	31.2	18.8	12.5	12.0
	6	34.2	24.4	16.3	16.0

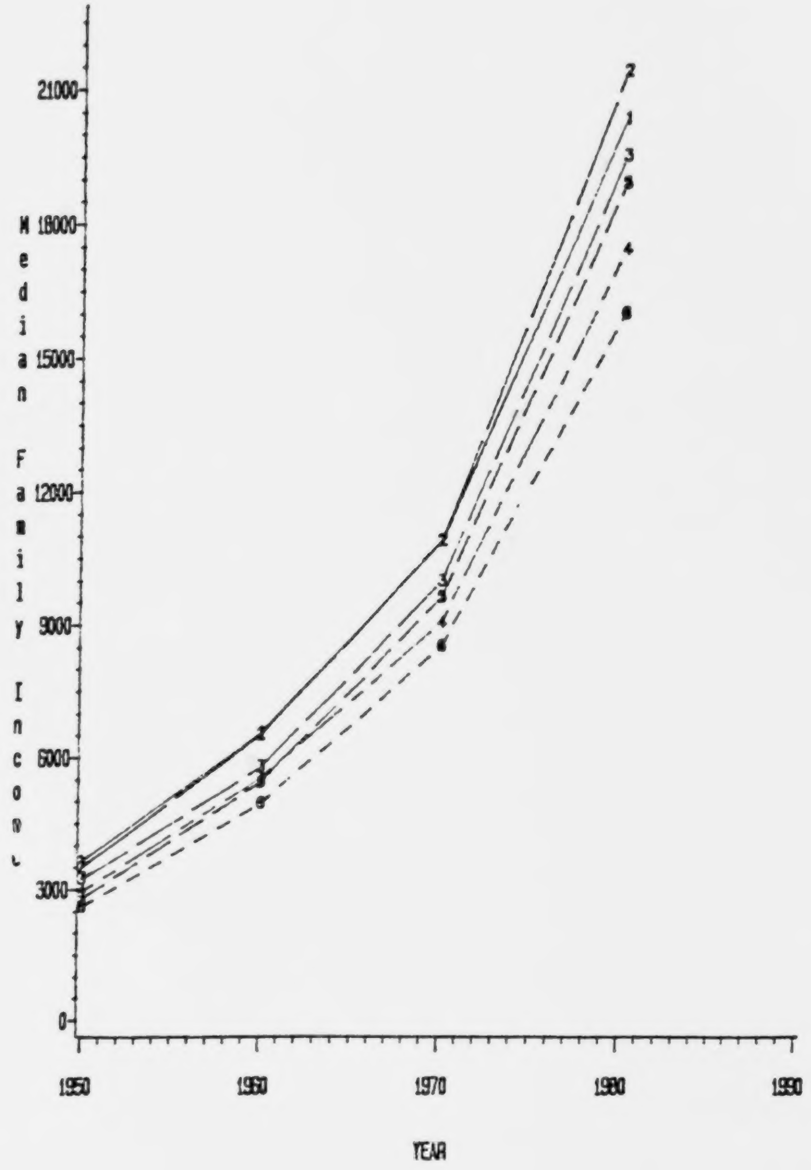
PERCENTAGE OF FAMILES IN AFFLUENCE

	COUNTY TYPE	1950	1960	1970	1980
	1	30.0%	22.2%	29.2 %	28.2 %
METRO	2	24.3	18.4	24.9	25.9
RURAL	3	20.2	13.4	19.1	19.9
	4	16.2	11.8	15.8	16.2
	5	14.5	11.0	17.7	18.9
	6	12.6	9.6	13.8	12.3

The above data, which are also represented in the following three graphs, were extracted from Paul Eberts' Socioeconomic Trends in Rural New York State: Toward the 21st Century. As can be seen, the median family income was consistently lower for rural counties over the thirty year period studied. Moreover, while there are variations in the percentages of families in poverty throughout the county types during that period, the percentages of families in affluence steadily decreased as the county type is defined as more rural. In general, it appears that the economic growth rate for the metropolitan county types was much higher than for the rural county types. In fact, the disparity in median family income between rural and metropolitan counties increased by 60% over the U.S. Census periods 1950-1980.

Although these data have not been adjusted for differences in cost of living, which is somewhat higher in metropolitan areas, they are nevertheless significant for policymaking purposes. For example, the costs of certain essential goods and services such as fuel, clothing, transportation, and food are generally higher in rural than in metropolitan areas. Similarly, the health status of a particular population has been found to correlate with its overall socioeconomic status.

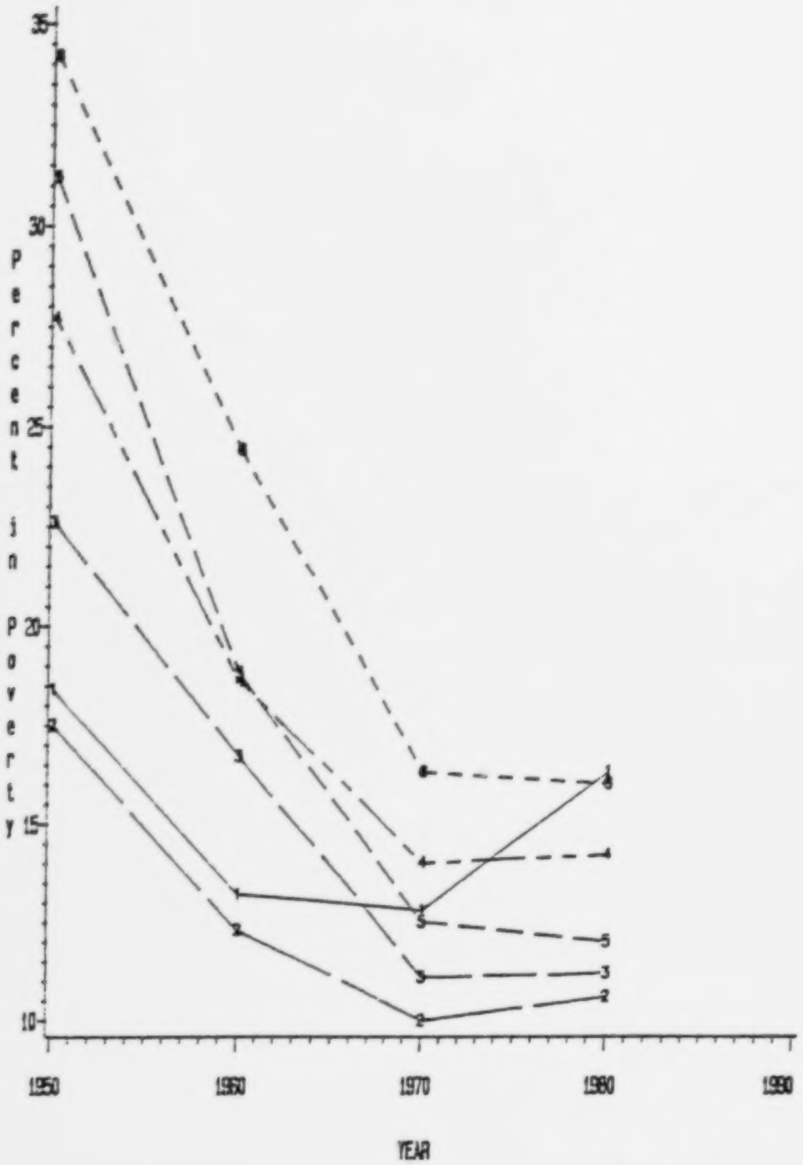
Median Family Income
in County Types 1–6, New York State, 1950–1980



The median family income, as shown here by county type, is the middle income earned for each category, with one half of the families receiving a greater income and one half receiving less.

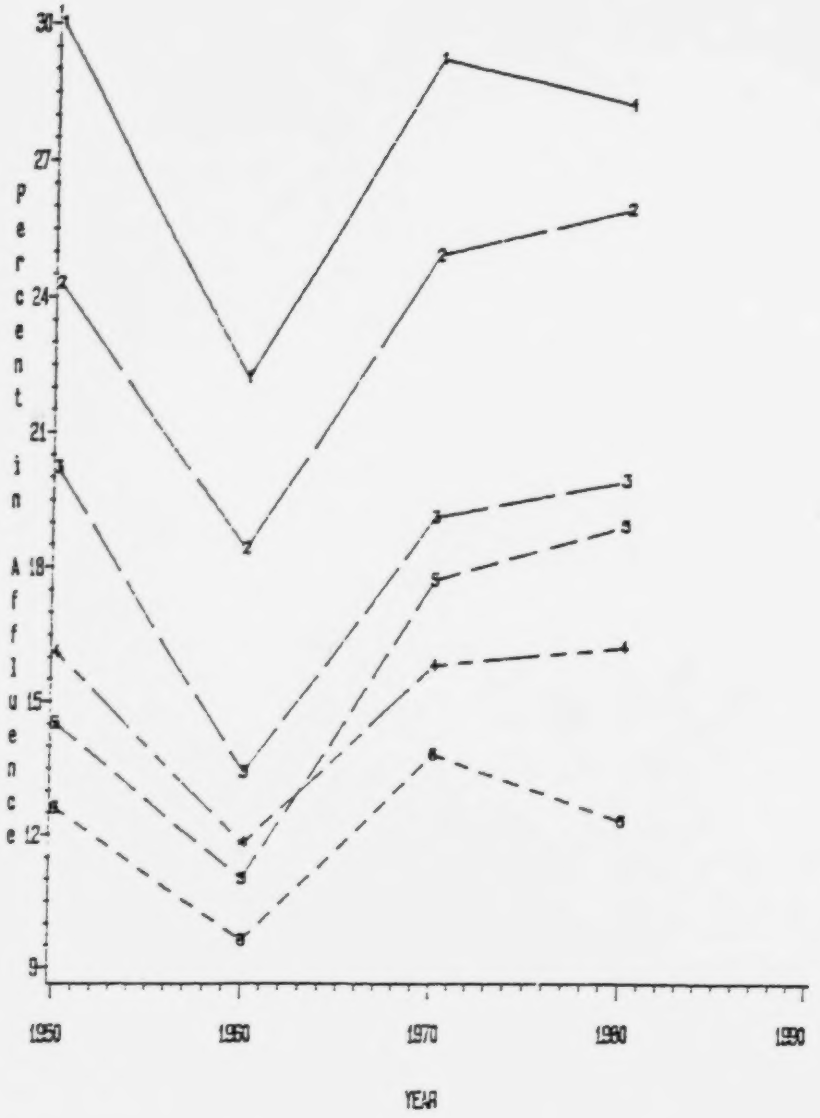
Source: Socioeconomic Trends in Rural New York State: Toward the 21st Century. Paul R. Eberts. 1984.

Percentage of Families in Poverty in County Types 1–6, New York State, 1950–1980



The percentage of families in poverty, as shown here by county type, is based on the U.S. Department of Agriculture's conception of how much money is necessary in order to live a healthy life, with adequate food, clothing, and shelter. For 1960, the break-point level for poverty was put at $3,000 or less for a family of four; and in 1970 it was put at $4,000 or less for a family of four; and in 1980 it was $7,500 or less for a family of four. The data above are the percentages of families below each one of these levels.

Percentage of Families in Affluence in County Types 1–6, New York State, 1950–1980



The percentage of families in affluence, as shown here by county type, is defined as the percentage of families with a total family income of $5,000 or more in 1950, $10,000 or more in 1960, $15,000 or more in 1970, and $30,000 or more in 1980. These levels put an aggregate average of slightly over 20% of the population in affluence for every county type in every time period (except 1960, when an average of only 17 percent was defined as the break-point because data for those with $8,000 or more were not available from computer tape).

Source: Eberts, Paul R. 1984.

TECHNOLOGY

Modern society is becoming more and more dependent on technology. Rural economies have benefitted from advances made, especially with respect to the mechanical age and its impact on the agricultural sector. Today, society is increasingly dependent on electronics and communications for its economic vitality, as witnessed by the rapid growth in commerce and productivity attributable to computers and telecommunications. The use and availability of such tools is increasing in rural areas, but at a much slower rate than metropolitan areas. This gap could widen and seriously reduce the competitive position of rural communities and citizens. The delivery of and access to quality health services in rural areas will be greatly affected by the availability of such technology.

The increased use of medical technology in health care, including homecare, means that rural providers will be compelled to keep up with these developments, which at the same time increases capital requirements because medical equipment is becoming increasingly sophisticated and expensive.

CLIENT NEEDS

- Health Status
  - Birth Rates
    - Births to Teenaged Mothers
    - Live Birth Rates
  - Death Rates
    - Infant Mortality
    - Crude Deaths
    - Heart Disease Deaths
    - Accidental Deaths
    - Suicides
  - Finance/Payors
    - Insured Persons
    - Medicaid Recipients
    - Physicians/Providers Accepting Medicaid
  - Networking Needs

SELECTED HEALTH INDICATORS

USING EBERTS METRO/RURAL TYPOLOGY OF COUNTIES
AND COUNTY POPULATION DENSITY

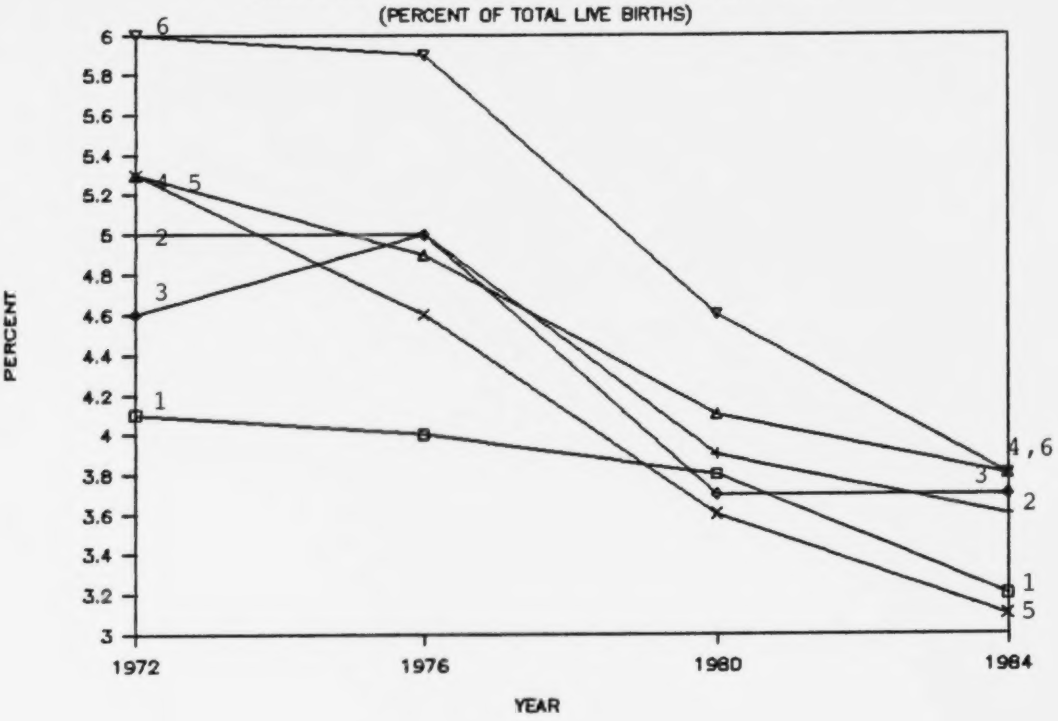
						Health Indicators							
N.Y.S. COUNTIES SCHEME		PCT POP GROWTH 80-90	PCT 65+ GROWTH 80-90	PCT 85+ GROWTH 80-90	1984 UNEMPL. RATE	1986 HOSP. BEDS /1000 POP	1985 PRIMARY MDS /1000 POP	1985 OTHR MDS /1000 POP	1985 PCT BIRTHS /1000 2500GR	1985 INFANT DEATHS UNDER BIRTHS	1985 BIRTHS /1000 FEMS 15-19	1985 CRUDE DEATH RATE	1985 CARDIO-VAS. DEATH RATE
EBERTS	1	2.5	14.5	60.7	7.3	4.5	1.1	1.8	7.7	11.8	9.6	9.7	0.47
METRO	2	1.2	19.2	35.9	6.6	4.0	0.8	1.2	6.2	9.2	9.7	9.5	0.75
RURAL	3	5.1	18.9	25.6	7.4	3.3	0.5	0.6	5.5	8.6	9.9	9.1	0.69
	4	5.3	15.8	28.9	7.9	4.2	0.5	0.7	5.4	9.3	11.3	9.4	0.71
	5	5.0	13.4	23.6	7.2	2.3	0.4	0.3	4.9	7.5	10.1	9.4	0.76
	6	3.6	11.8	21.8	8.2	3.4	0.5	0.4	6.0	8.9	12.8	10.6	0.80
POPULATION DENSITY	*1	2.3	15.7	52.7	7.1	4.3	1.0	1.6	7.2	11.1	9.6	9.6	0.54
	**0	5.2	15.6	25.7	8.2	3.4	0.4	0.5	5.5	8.3	11.5	9.7	0.75

*	1	(Counties over 150 persons/sq. mile) -	24
**	0	(Counties under 150 persons/sq. mile) -	38
			62

Source: New York State Department of Health

BIRTHS TO MOTHERS UNDER 18

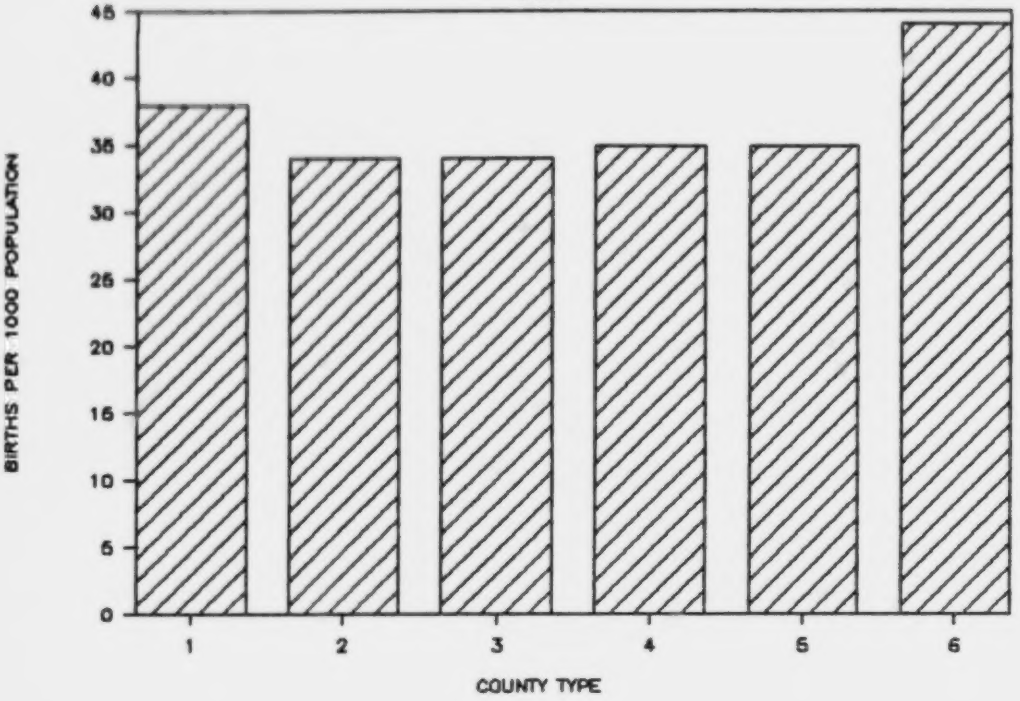
(PERCENT OF TOTAL LIVE BIRTHS)



County Type		1972	1976	1980	1984
Metro	1	4.1	4.0	3.8	3.2
	2	5.0	5.0	3.9	3.6
	3	4.6	5.0	3.7	3.7
	4	5.3	4.9	4.1	3.8
Rural	5	5.3	4.6	3.6	3.1
	6	6.0	5.9	4.6	3.8

Over the period 1972 - 1984, the percentage of live births for mothers under 18 fell for all county types. The most drastic declines occurred in the two most rural county types--over 2% in both cases. The difference between the most rural county type and the most urban was 1.9% in 1972; by 1984 this difference had narrowed to 0.6%.

Source: New York State Department of Health



BIRTHS TO MOTHERS AGED 15-19
1985

Table 1
BIRTHS TO MOTHERS AGED 15 - 19 (1985)

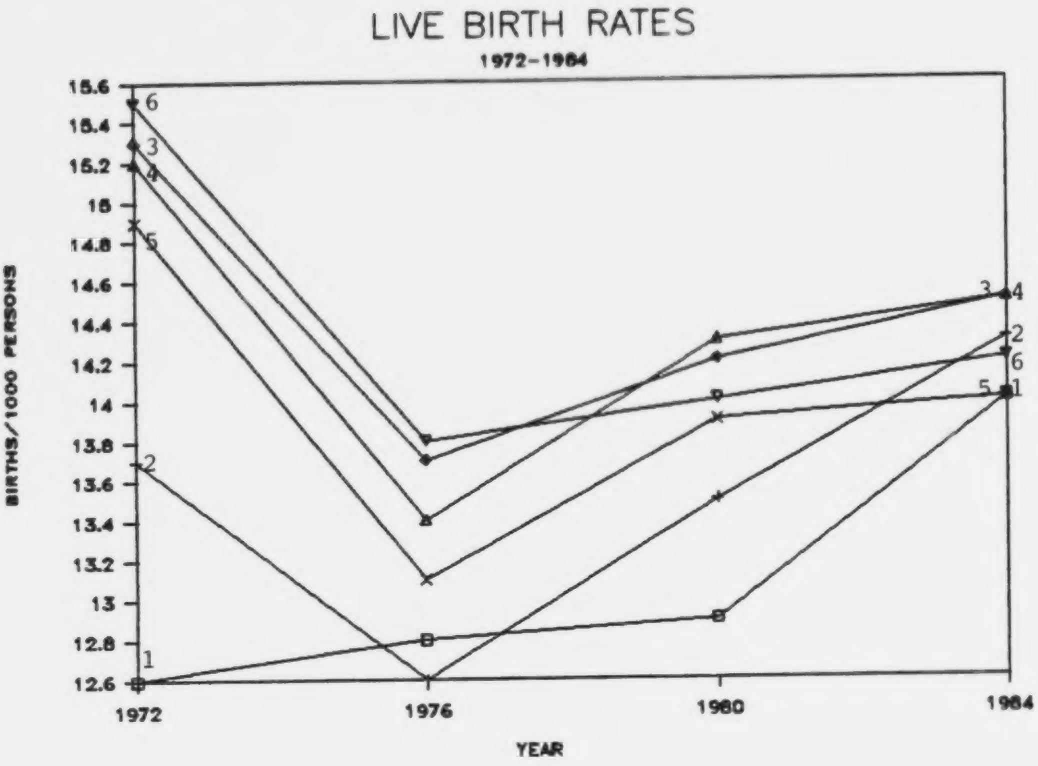
County Type		Number of Births
1	Metro	38
2		34
3	Rural	34
4		35
5		35
6		44

Table 2 (1984)
ABORTIONS PER 1000 LIVE BIRTHS

County Type	Number of Abortions
1	788.78
2	412.83
3	172.48
4	70.06
5	66.86
6	90.62

As can be seen from the graph, in 1985 the number of births to mothers aged 15 - 19 was somewhat higher in the most rural county type 6. In table 2, 1984 data reveal that the number of abortions per 1000 live births is much lower in rural county types.

Source: New York State Department of Health



LIVE BIRTH RATES* BY COUNTY TYPE 1972 - 1984

County Type		1972	1976	1980	1984
Metro	1	12.6	12.8	12.9	14.0
	2	13.7	12.6	13.5	14.3
Rural	3	15.3	13.7	14.2	14.5
	4	15.2	13.4	14.3	14.5
	5	14.9	13.1	13.9	14.0
	6	15.5	13.8	13.0	14.2

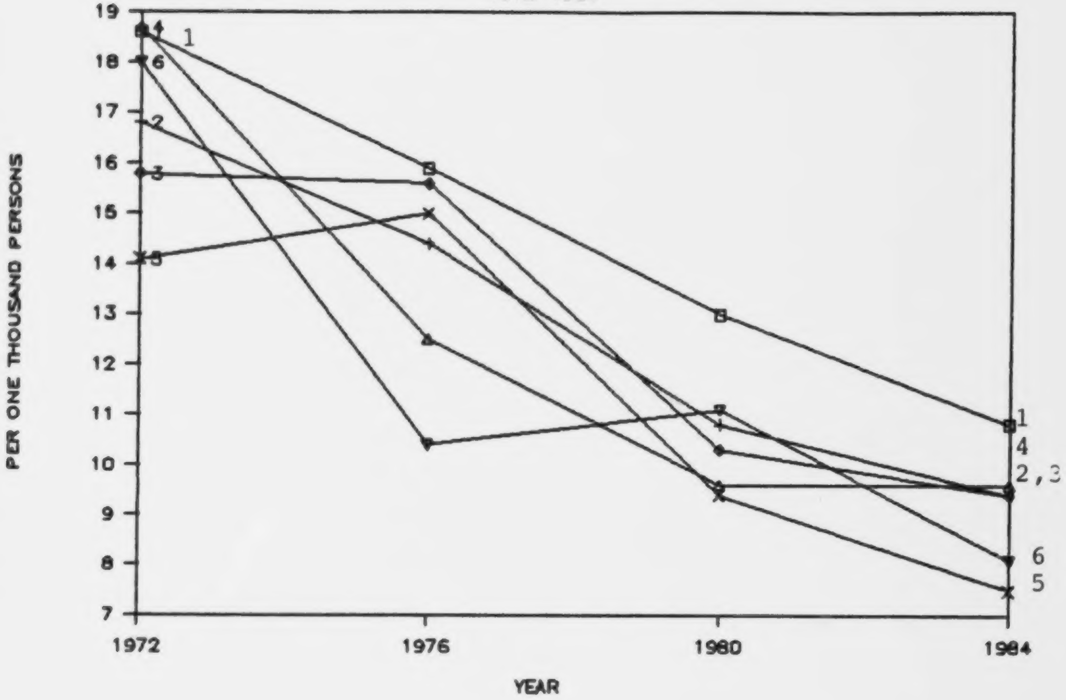
* per one thousand population

The live birth rates for the two metropolitan county types increased overall from 1972 to 1984, while the four rural county types experienced decreases in overall live birth rates. While the most metropolitan county type and the most rural county type had a live birth rate difference of 2.9 in 1972, by 1984 the rates for all county types were within .5 of one another. Thus, the disparities in live birth rates for the different county types have decreased significantly.

Source: New York State Department of Health

INFANT MORTALITY RATES

1972–1984

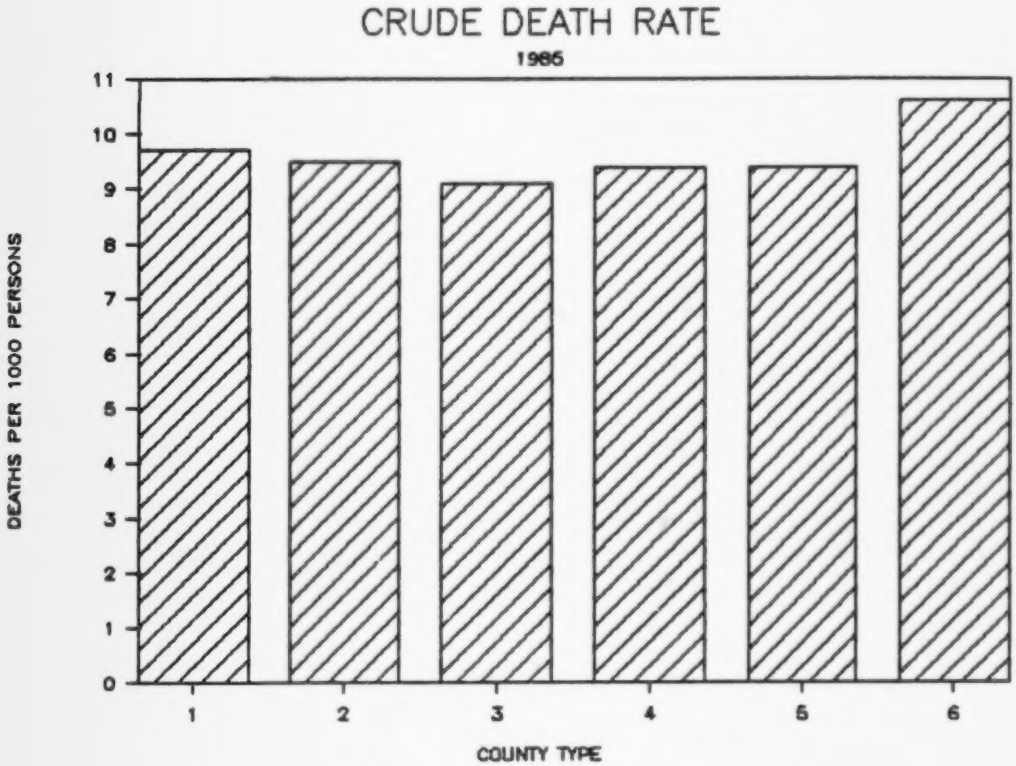


INFANT MORTALITY RATES 1972 - 1984 BY COUNTY TYPE

County Type		1972	1976	1980	1984
Metro	1	18.6	15.9	13.0	10.8
	2	16.8	14.4	10.8	9.4
Rural	3	15.8	15.6	10.3	9.4
	4	18.7	12.5	9.5	9.6
	5	14.1	15.0	9.4	7.5
	6	18.0	10.4	11.1	8.1

Infant mortality rates have declined for all county types over the period 1972 - 1984. Dramatic reductions in infant mortality occurred in the most rural areas.

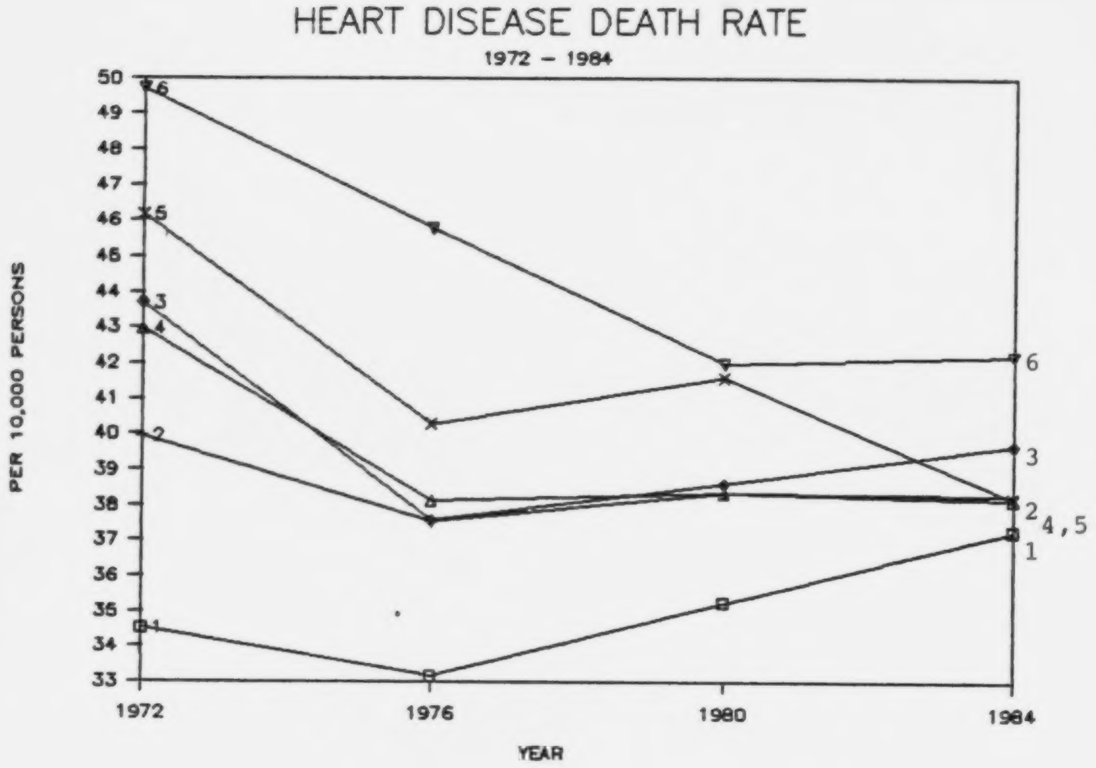
Source: New York State Department of Health



County Type	Crude Death Rate (per 1000 persons)
1	9.7
2	9.5
3	9.1
4	9.4
5	9.4
6	10.6

The crude death rate (the annual number of deaths per 1000 persons, of all causes) is highest in the most rural county type (6). Factors which influence these rates may include higher suicide rates and accident rates (automobile and farm related vehicles), along with lifestyle (smoking, dietary habits and exercise), as well as a lack of education and awareness.

Source: New York State Department of Health



HEART DISEASE DEATH RATES* BY COUNTY TYPE 1972 - 1984

County Type	1972	1976	1980	1984
1	34.5	33.2	35.2	37.3
2	39.9	37.5	38.4	38.3
3	43.7	37.6	38.6	39.7
4	43.0	38.1	38.3	38.2
5	46.2	40.3	41.6	38.2
6	49.7	45.8	42.0	42.3

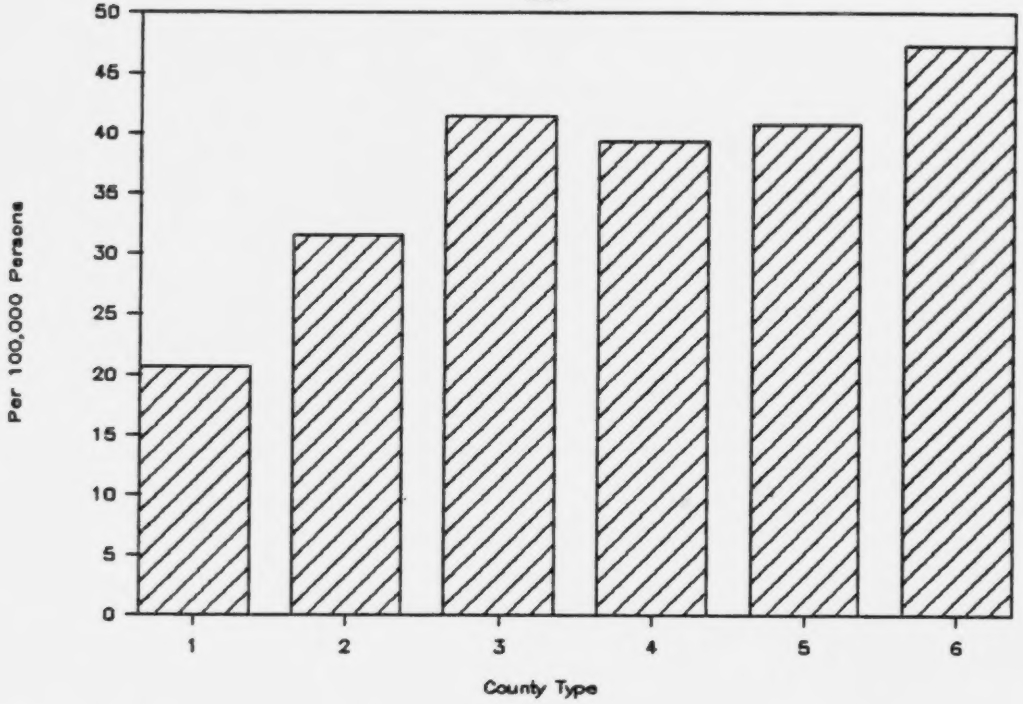
* per one hundred thousand

The period 1972-1984 saw heart disease death rates fall for all county types, with the exception of county type 1 - Downstate Metropolitan. Although the heart disease death rate increased steadily after 1976 for the Downstate Metropolitan county type, this group still had the lowest rate of any county type. By 1984 only the most rural county type had a heart disease death rate above 40 deaths per 10,000 population.

Source: New York State Department of Health

ACCIDENT DEATH RATE

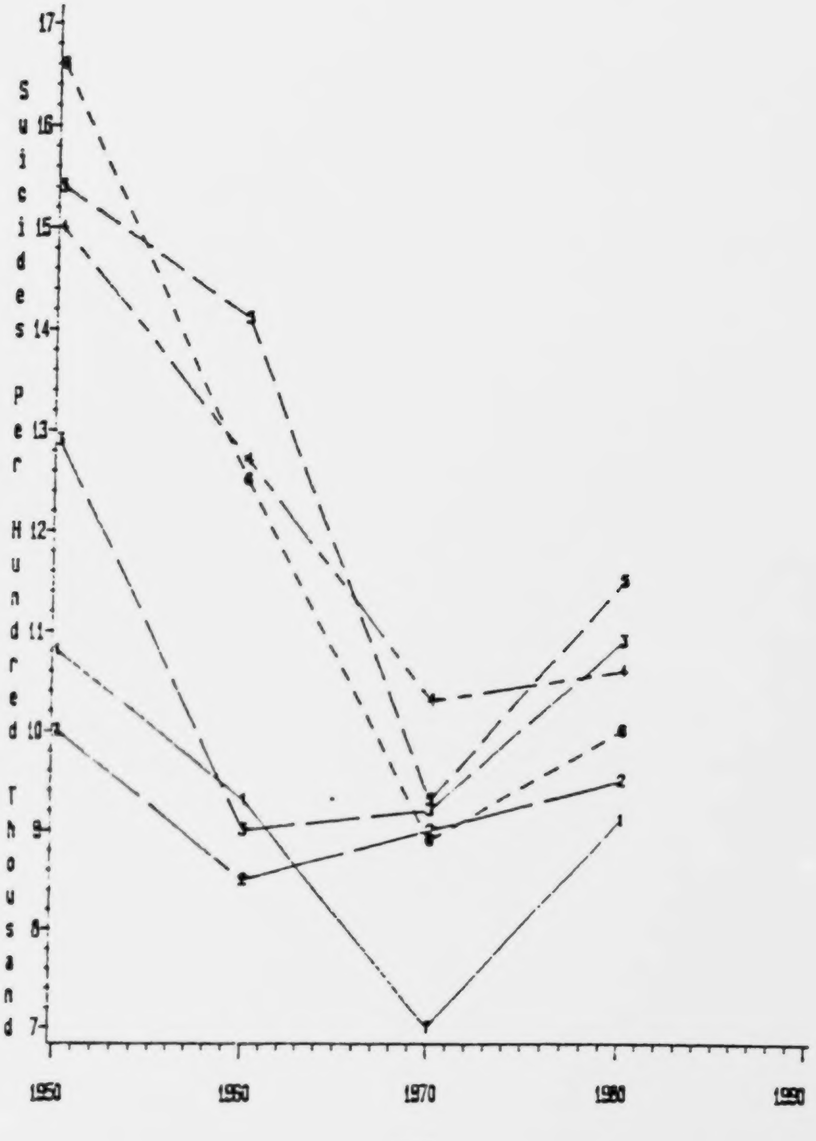
1984



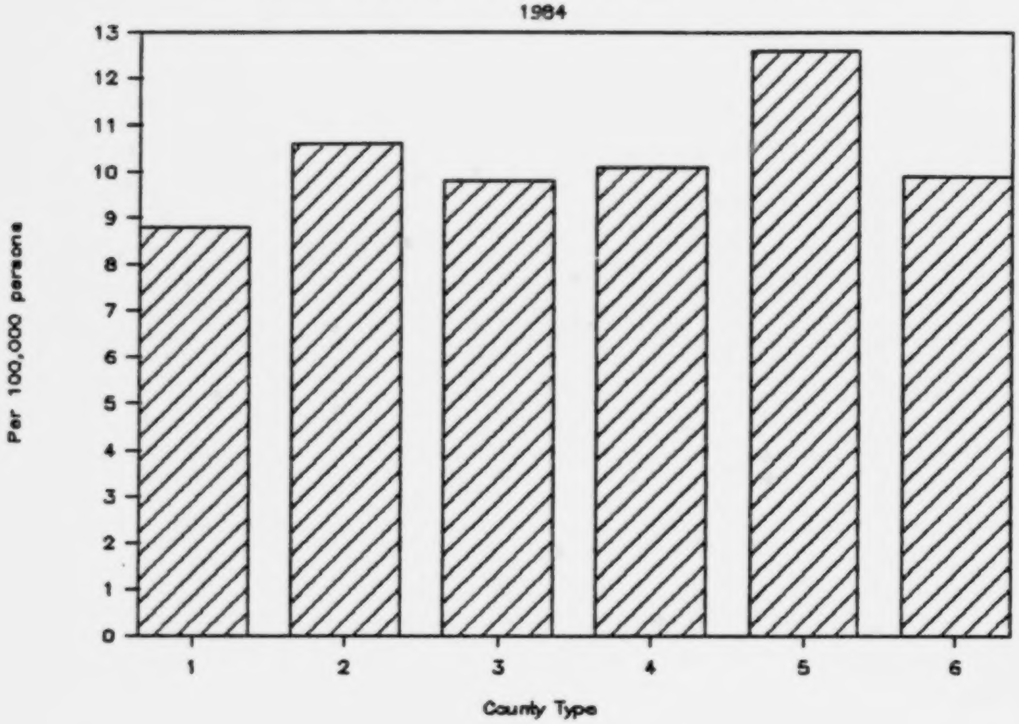
The accidental death rate in rural counties is consistently higher than in metropolitan counties. The death rate from accidents for the most rural counties (type 6) was more than twice the level of the downstate metropolitan counties (type 1). This can be partially attributed to sparse populations and limited or non-existent emergency medical services. Occupationally-related accidents are numerous in rural areas where farming, forestry, and industrial manufacturing employment are common and present a greater risk of life-threatening injury. Rural highways, in many cases, are narrow and winding, which lengthens the time it takes for emergency vehicles to reach an accident or fire. In addition, rural communities often find difficulties in staffing and funding full-time volunteer ambulance services. Because of the dearth of readily accessible medical facilities, and time-distance factors, the survival rate in rural areas may tend to be lower.

Source: New York State Department of Health

Number of Suicides per Hundred Thousand Persons in County Types 1–6, New York State, 1950–1980



Source: Eberts, Paul R., 1984.



SUICIDE RATE BY COUNTY TYPE

1984

Three trends can be identified from the graph of suicide rates over the period 1950 - 1980: 1) suicide rates declined steadily until 1970, but increased from 1970 to 1980; 2) the gaps between county types with the highest and lowest suicide rates have narrowed; and 3) metropolitan counties experienced lower suicide rates than rural counties over this 30-year period.

Recent (1984) data show a continuation, for the most part, of the first two trends. However, upstate metropolitan counties (type 2) had the second highest suicide rate in 1984. Thus, it will be important to continue monitoring the suicide rate in order to determine if significant changes in the third trend are occurring.

Source: New York State Department of Health

INSURED PERSONS

There is currently little aggregate data on a county-by-county basis regarding the number of people covered by some type of medical insurance. However, several categories of persons at risk of not being covered are highly represented in rural areas of the state. These high risk persons include:

- the unemployed and the working poor who are not eligible for Medicaid;
- self-employed persons, (eg., in agriculture), who must provide their own coverage; and
- persons employed in small businesses, with no employer-subsidized or group health plan.

Medicaid (1985)*

County Type		Percent of Eligible Population Receiving Medicaid Benefits
1	Metro	65.07
2		55.59
3	Rural	59.04
4		57.50
5		58.99
6		58.51

The table above shows by county type, the percentage of N.Y.S. residents in 1985, eligible for medicaid who were actually receiving benefits. One of the factors used in determining a recipient's eligibility is the poverty level, which for 1980 was $7,500 or less for a family of four.

The New York Metropolitan Region (type 1), has the bulk of New York State's impoverished (65.30%). Also, a relatively high percentage of people eligible for Medicaid in this region make use of these benefits. The percentage of persons eligible for Medicaid in rural areas who are actually receiving benefits is consistently lower. Some reasons for this occurrence are the limited access to information regarding health options and services in rural areas, along with fewer health support services such as home health care.

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*Source: Statistical Supplement to the 1985 Annual Report of the New York State Department of Social Services, 1986.

Physicians/Providers Accepting Medicaid

Despite much lower reimbursement rates (statewide) than for other payment plans, rural practitioners have traditionally accepted more Medicaid patients than their urban counterparts:

Physician Participation in Medicaid (1978)*

	Patients Receiving Medicaid	Physicians Taking New Medicaid Patients
Large MSA*	12.9%	49.7%
Small MSA*	16.2%	55.2%
Non-MSA*	16.4%	59.9%

*MSA = Metropolitan Statistical Area

Currently, however, reports are that many rural physicians are becoming discouraged by difficulties associated with treating Medicaid patients. Specific problems include the extremely low reimbursement rates for Medicaid patients, as well as cumbersome paperwork, and an increase in the number of claims that are rejected or need to be resubmitted.

- According to one rural county Health Commissioner, the lack of available pediatric services for Medicaid recipients in the Dunkirk-Fredonia area has become a "serious problem." County visiting nursing staffs have been receiving calls from mothers of infants requiring medical treatment who claim they have no access to a physician's services. Physicians are limiting their services because they are dissatisfied with the reimbursement rates. Consequently, there are a significant number of children not being seen in that area, and an increase in the usage of more costly emergency medical services.

- The head of the Pediatric Society of the Southern Tier, who says his own practice is 15-20% Medicaid, stated that "At least half the pediatricians are not taking new Medicaid patients - period!"

*Source: U.S. Department of Health, Education, and Welfare, 1978.

Networking Needs of Individual Clients

The rural consumer of health care services must be provided with methods and capabilities with which to access the full continuum of services, including awareness of those services and providers that are most appropriate and useful to meet his or her needs.

Specific networking needs of the individual client include:

- awareness of his or her needs as a health care consumer, and the various health care services available to meet those needs;
- information and education, to allow the consumer to choose the service most appropriate for his or her needs, as well as knowledge of his or her eligibility for various payment programs;
- access to the full continuum of health and health-related services that are available to meet individual needs;
- linking and support services (e.g., transportation, human/social services), in order to better enable the consumer to obtain appropriate health care services;
- increased coordination/central intake and assessment, to ensure that the client is receiving needed services, while avoiding unnecessary duplication or discontinuity in receiving such services.

PROVIDERS

- Availability of Services
  - Medically Underserved Areas and Health Manpower Shortage Areas
  - Physician Distributions
    - Primary Care
    - Specialists
    - Obstetricians/Gynecologists
    - Pediatricians
  - Hospitals
    - Admission Rates
    - Length of Stay
    - Distribution of Beds
  - Clinics
  - Emergency Medical Services
  - Long Term Care
  - Health Maintenance Organizations
- Reimbursement
  - Medicare
  - Medicaid
  - Worker's Compensation
  - Blue Shield
- Health Care Personnel
  - Recruitment and Retention
  - Roles of Health Care Workers
  - Certification
  - Training
- Networking and Coordination

MEDICALLY UNDERSERVED AREAS AND HEALTH MANPOWER SHORTAGE AREAS

The maps on the following two pages indicate the latest federal designations of Medically Underserved Areas (MUAs) and Health Manpower Shortage Areas for Primary Care (HMSAs). Following is a brief summary of how they are designated and their implications.

Medically Underserved Areas (MUAs)

MUAs are designated by the Secretary of Health and Human Services, and are reviewed and updated periodically. Former designations are commented on by local HSAs and the State Health Department. Criteria to define MUAs are based on a total score of four measures:

(1) ratio of primary care physicians to the population;
(2) infant mortality rates;
(3) percentage of the population who are 65 years or older;
(4) percentage of the population with incomes below poverty level.

Each of these measures is weighted, and the result is the Index of Medical Underservice (IMU). The median IMU is considered the cutoff point; geographic areas having IMU scores below that point are designated as medically underserved.

The implications of being designated an MUA are varied. For example, a project serving at least 30% of its clients from MUAs may receive priority funding under the Health Maintenance Organization Act. In addition, public and nonprofit entities may apply for grants to plan, develop, and/or operate community health centers in MUAs. At the state level, the State Health Department consideres MUA designations in approving grant and Certificate of Need applications.

Health Manpower Shortage Areas (HMSAs)

Health Manpower Shortage Areas are also designated by the Secretary of HHS, and are reviewed annually. The recommended designations are commented upon by the HSAs, State Health Department, Governor's office, and State Medical Society.

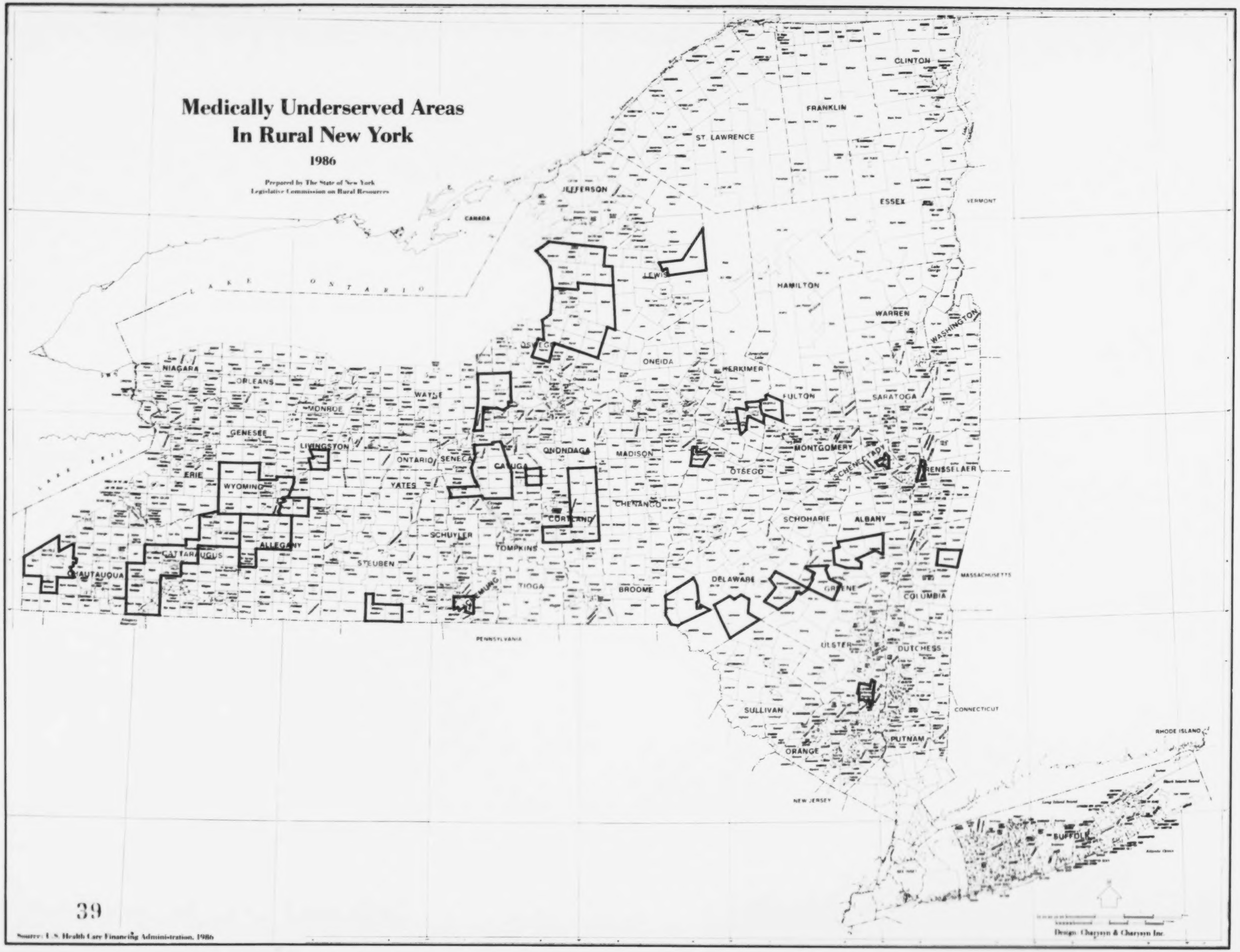
Criteria are defined for seven health manpower types: primary care, dental, psychiatric, vision care, podiatric, pharmacy, and veterinary.

Public or nonprofit entities located in HMSAs are eligible to apply for assignment of National Health Services Corps (NHSC) personnel. They also receive priority consideration for Public Health Service scholarship, loan repayment and nurse practitioner traineeship programs, as well as for PHS grant programs. The State Health Department also uses HMSA designations in considering grant applications.

Medically Underserved Areas In Rural New York

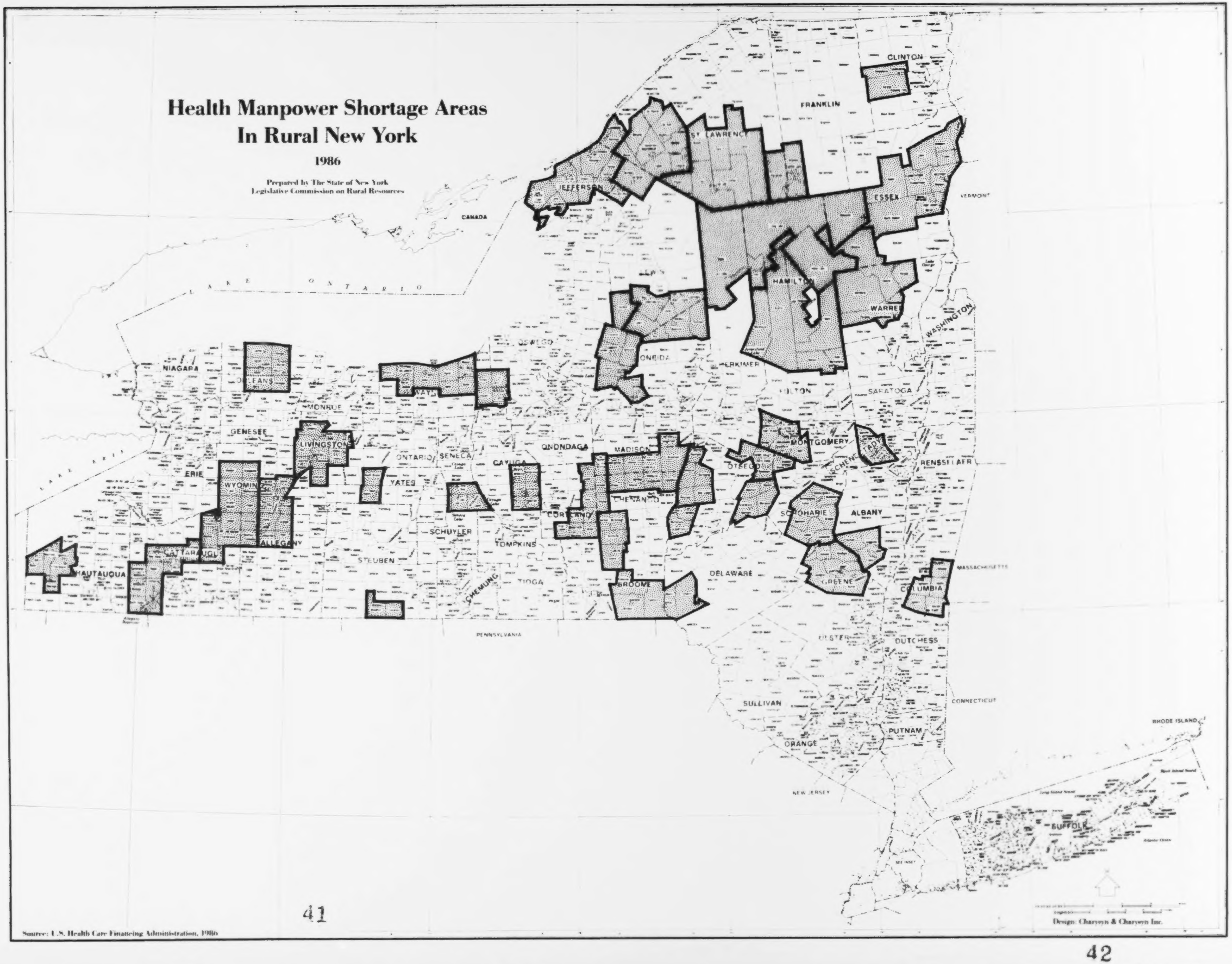
1986

Prepared by The State of New York
Legislative Commission on Rural Resources


CANADA
LAKE ONTARIO
LAKE ERIE
CLINTON
FRANKLIN
ST LAWRENCE
JEFFERSON
ESSEX
VERMONT
LEWIS
HAMILTON
WARREN
WASHINGTON
OSWEGO
ONEIDA
HERKIMER
NIAGARA
ORLEANS
WAYNE
MONROE
FULTON
SARATOGA
GENESEE
LIVINGSTON
ONTARIO
SENECA
CAYUGA
ONONDAGA
MADISON
MONTGOMERY
SCHENECTADY
RENSSELAER
ERIE
WYOMING
YATES
OTSEGO
CORTLAND
CHENANGO
SCHOHARIE
ALBANY
ALLEGANY
SCHUYLER
TOMPKINS
CATTARAUGUS
CHAUTAUQUA
STEUBEN
CHEMUNG
TIOGA
BROOME
DELAWARE
GREENE
COLUMBIA
MASSACHUSETTS
PENNSYLVANIA
ULSTER
DUTCHESS
CONNECTICUT
SULLIVAN
PUTNAM
ORANGE
RHODE ISLAND
NEW JERSEY
SUFFOLK

Design: Charysyn & Charysyn Inc.

Source: U.S. Health Care Financing Administration, 1986



CLINTON
FRANKLIN
ST. LAWRENCE
JEFFERSON
ESSEX
VERMONT
CANADA
LAKE ONTARIO
LEWIS
HAMILTON
WARREN
WASHINGTON
OSWEGO
ONEIDA
HERKIMER
NIAGARA
ORLEANS
WAYNE
MONROE
FULTON
SARATOGA
GENESEE
LIVINGSTON
MONTGOMERY
SCHENECTADY
ONTARIO
SENECA
CAYUGA
ONONDAGA
MADISON
RENSSELAER
LAKE ERIE
ERIE
WYOMING
YATES
OTSEGO
CHENANGO
SCHOHARIE
ALBANY
CORTLAND
SCHUYLER
TOMPKINS
ALLEGANY
CATTARAUGUS
CHAUTAUQUA
STEUBEN
CHEMUNG
TIOGA
BROOME
DELAWARE
GREENE
COLUMBIA
MASSACHUSETTS
PENNSYLVANIA
ULSTER
DUTCHESS
SULLIVAN
CONNECTICUT
PUTNAM
ORANGE
RHODE ISLAND
NEW JERSEY
SUFFOLK

Health Manpower Shortage Areas In Rural New York

1986

Prepared by The State of New York
Legislative Commission on Rural Resources

Source: U.S. Health Care Financing Administration, 1986

Design: Charysyn & Charysyn Inc.

PHYSICIAN DISTRIBUTION

The graphs and data on this and the following page show the distributions of physicians in the six county types for 1970, 1980, and 1985. Using this information, the following observations are made:

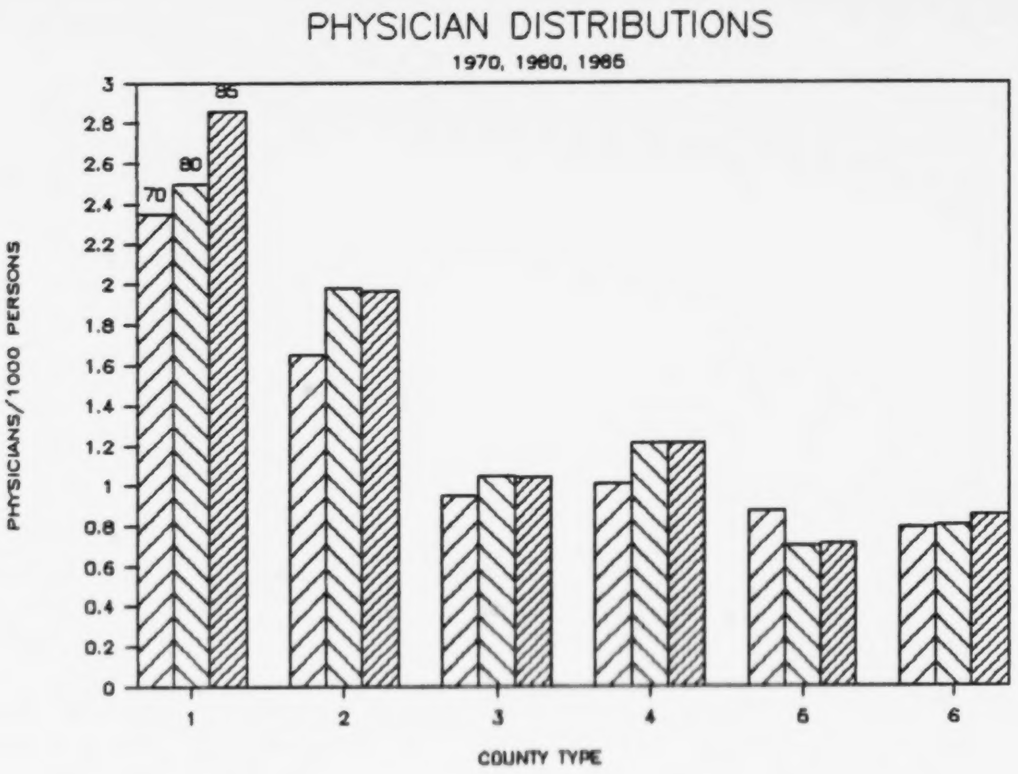
- The distribution of both primary care physicians and physician specialists is significantly lower in rural than in the urban counties;
- Although the number of practicing physicians has increased over the past 15 years, the increase in rural counties has for the most part been minimal

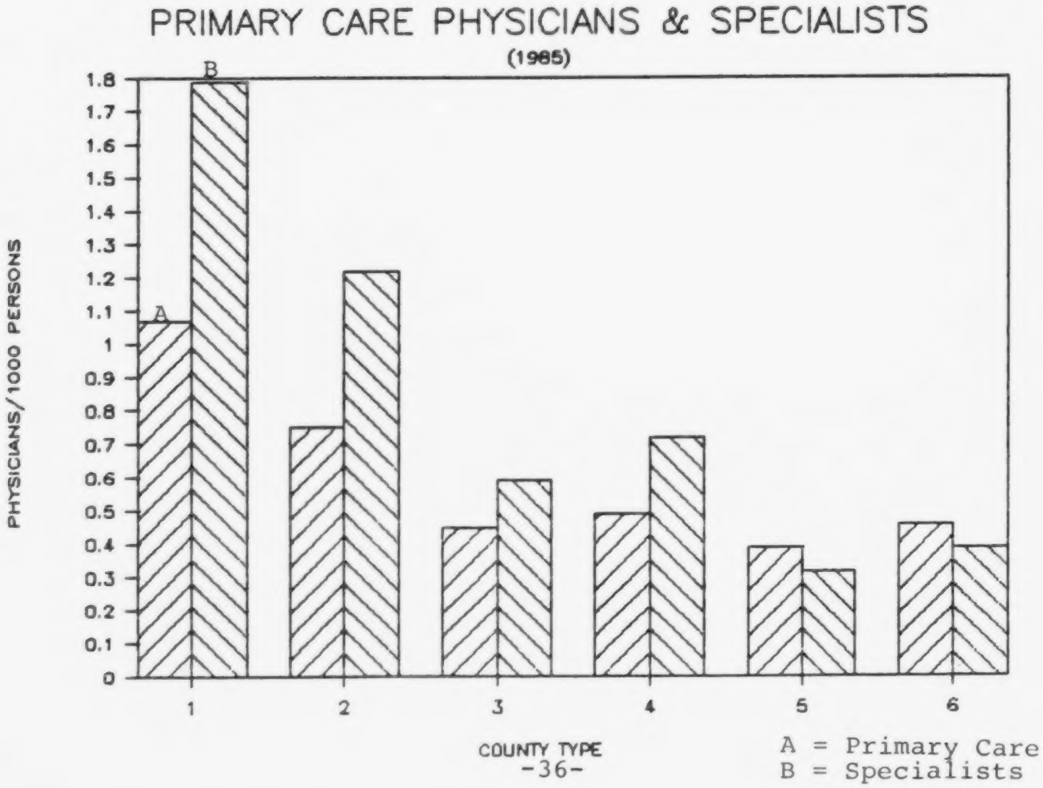
  -- for example, the number of physicians in rural county type 6 increased 7.6% from 1970 to 1985, while for county type 1 the number of physicians increased 21.7% for the same time span (and the number of physicians practicing in rural county type 5 actually decreased by 18.4%).

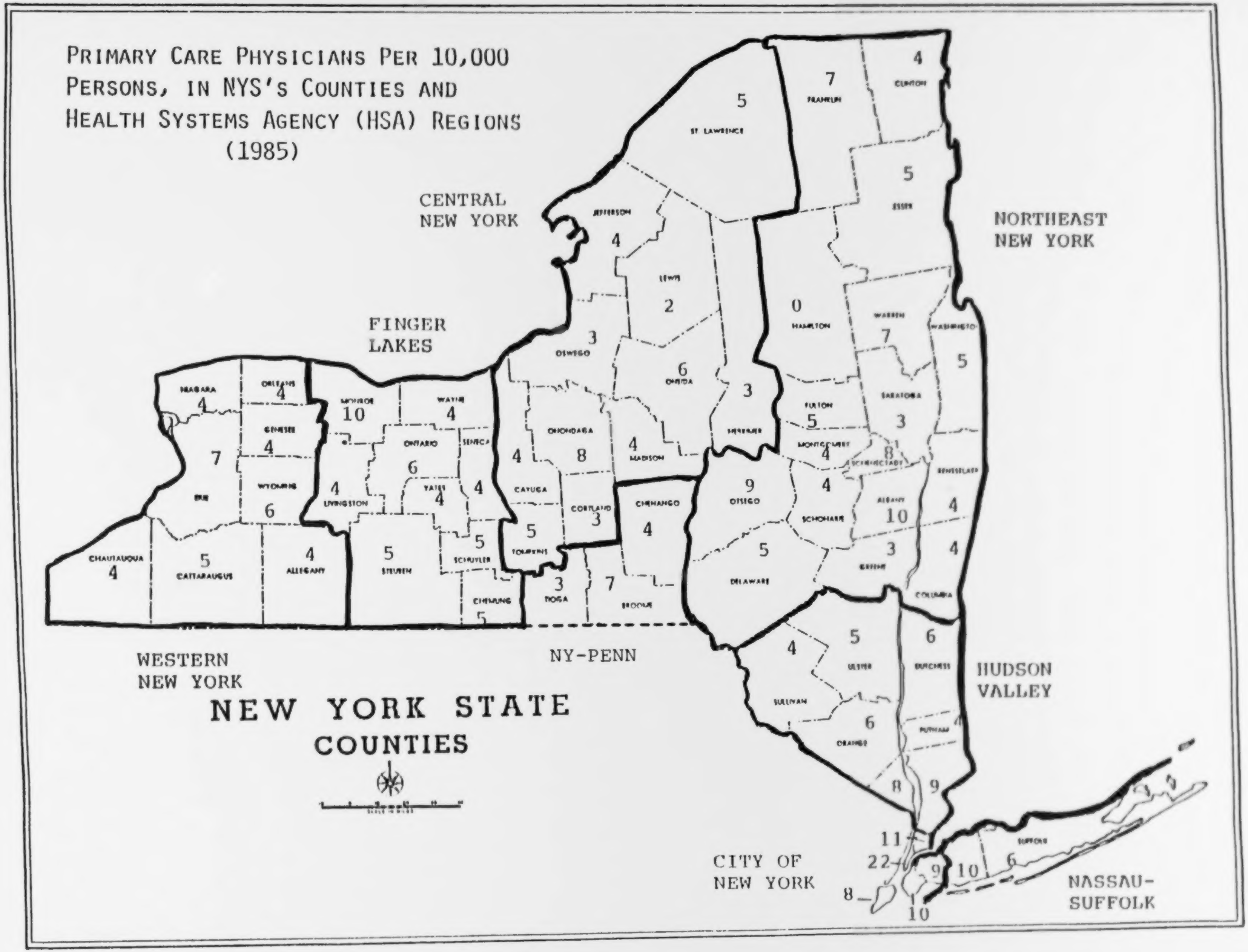
	COUNTY TYPE	PHYSICIANS PER 1000			PERCENT INCREASE (1970-1985)	1985 (PHYSICIANS PER 1000)	
		1970	1980	1985		PRIMARY CARE	SPECIALISTS
	1	2.35	2.50	2.86	21.7%	1.07	1.79
METRO	2	1.65	1.98	1.97	19.4	0.75	1.22
RURAL	3	0.95	1.05	1.04	9.5	0.45	0.59
	4	1.01	1.21	1.21	19.8	0.49	0.72
	5	0.87	0.70	0.71	-18.4	0.39	0.32
	6	0.79	0.80	0.85	7.6	0.46	0.39

Sources: Recommendations for Financing Ambulatory Care in Non-Hospital Settings. New York State Council on Health Care Financing. October 1983.

New York State Education Department: 1985 Survey of Medical Doctors.


PHYSICIAN DISTRIBUTIONS
1970, 1980, 1985
PHYSICIANS/1000 PERSONS
3
2.8
2.6
2.4
2.2
2
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
70
80
85
1
2
3
4
5
6
COUNTY TYPE


PRIMARY CARE PHYSICIANS & SPECIALISTS
(1985)
PHYSICIANS/1000 PERSONS
1.8
1.7
1.6
1.5
1.4
1.3
1.2
1.1
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
A
B
1
2
3
4
5
6
COUNTY TYPE
A = Primary Care
B = Specialists

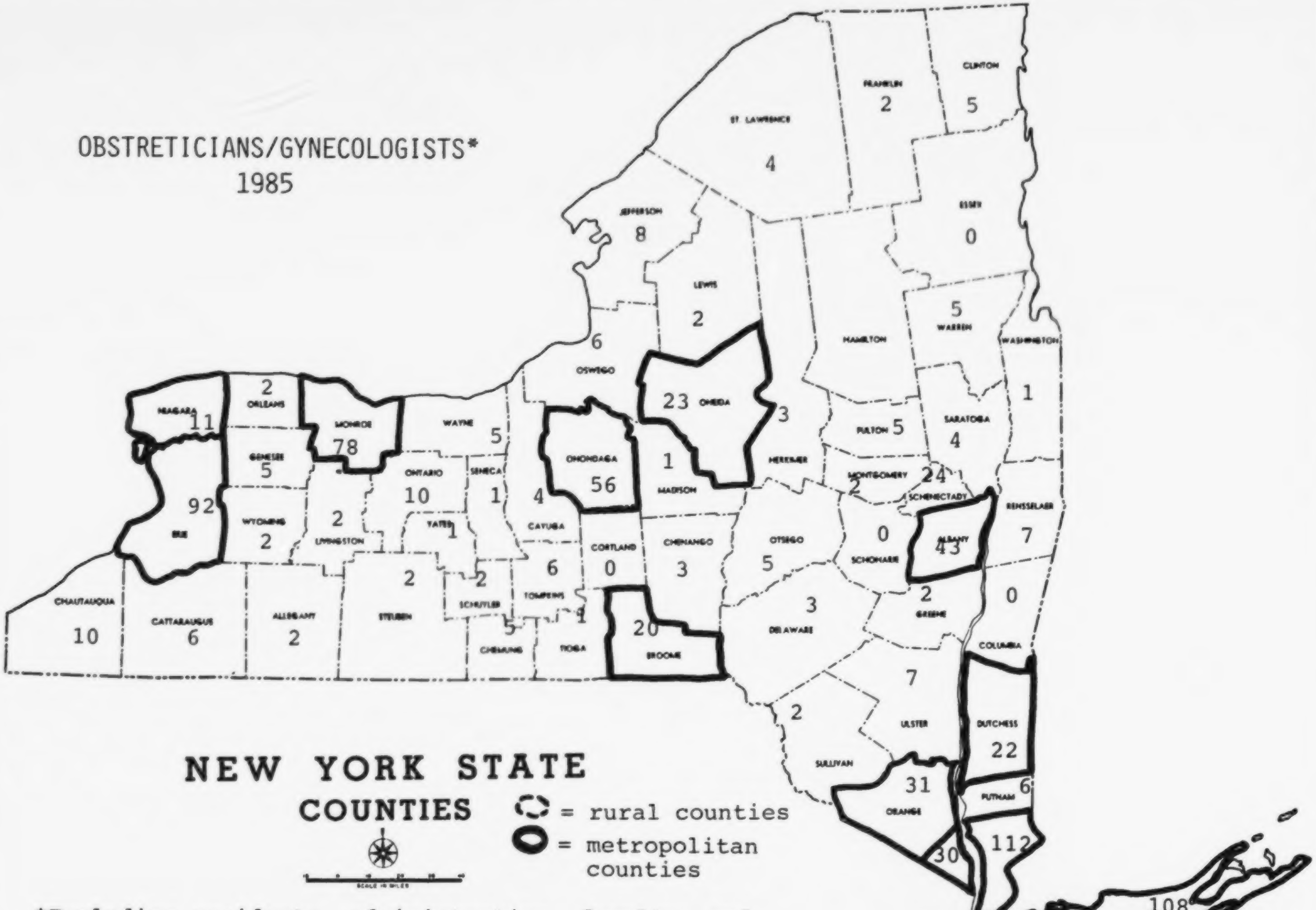


PRIMARY CARE PHYSICIANS PER 10,000 PERSONS, IN NYS'S COUNTIES AND HEALTH SYSTEMS AGENCY (HSA) REGIONS (1985)

NEW YORK STATE COUNTIES

CENTRAL NEW YORK
FINGER LAKES
NORTHEAST NEW YORK
WESTERN NEW YORK
NY-PENN
HUDSON VALLEY
CITY OF NEW YORK
NASSAU-SUFFOLK
NIAGARA 4
ORLEANS 4
MONROE 10
WAYNE 4
GENESEE 4
ERIE 7
WYOMING 6
LIVINGSTON 4
ONTARIO 6
SENECA 4
YATES 4
CHAUTAUQUA 4
CATTARAUGUS 5
ALLEGANY 4
STEUBEN 5
SCHUYLER 5
CHEMUNG 5
JEFFERSON 4
OSWEGO 3
LEWIS 2
ONEIDA 6
ONONDAGA 8
MADISON 4
CAYUGA 4
CORTLAND 3
TOMPKINS 5
CHENANGO 4
TIOGA 3
BROOME 7
ST LAWRENCE 5
FRANKLIN 7
CLINTON 4
ESSEX 5
HAMILTON 0
HERKIMER 3
WARREN 7
WASHINGTON 5
SARATOGA 3
FULTON 5
MONTGOMERY 4
SCHENECTADY 8
OTSEGO 9
SCHOHARIE 4
ALBANY 10
RENSSELAER 4
DELAWARE 5
GREENE 3
COLUMBIA 4
SULLIVAN 4
ULSTER 5
DUTCHESS 6
ORANGE 6
PUTNAM
8
9
11
22
8
9
10
10
SUFFOLK 6

OBSTRETICIANS/GYNECOLOGISTS*
1985

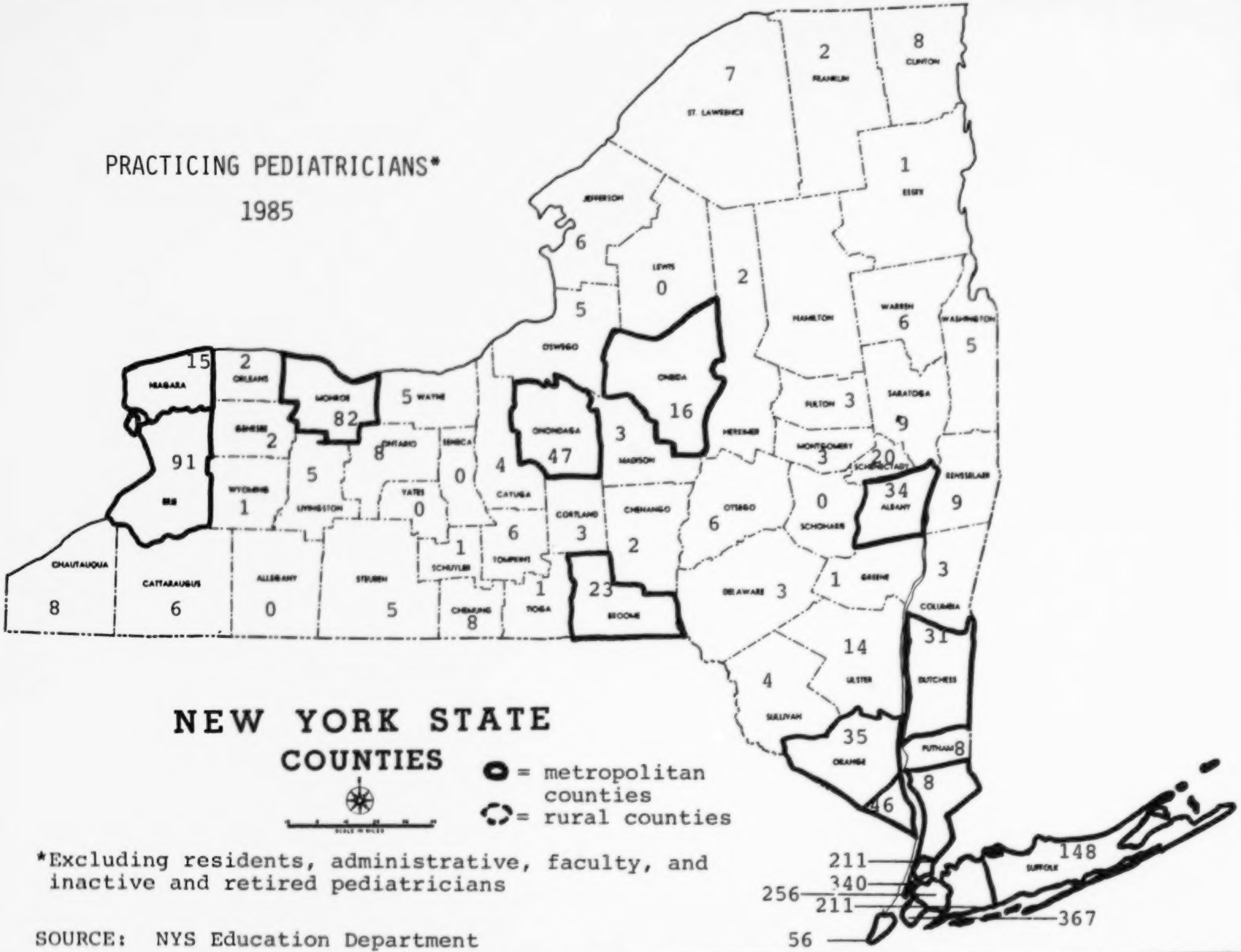

NEW YORK STATE
COUNTIES
= rural counties
= metropolitan counties
SCALE IN MILES
NIAGARA 11
ORLEANS 2
MONROE 78
WAYNE 5
OSWEGO 6
JEFFERSON 8
ST. LAWRENCE 4
FRANKLIN 2
CLINTON 5
ESSEX 0
LEWIS 2
HAMILTON
WARREN 5
WASHINGTON 1
ERIE 92
GENESEE 5
WYOMING 2
LIVINGSTON 2
ONTARIO 10
YATES 1
SENECA 1
CAYUGA 4
ONONDAGA 56
ONEIDA 23
HERKIMER 3
FULTON 5
SARATOGA 4
MADISON 1
MONTGOMERY 2
SCHENECTADY 24
RENSSELAER 7
CORTLAND 0
CHENANGO 3
OTSEGO 5
SCHOHARIE 0
ALBANY 43
CHAUTAUQUA 10
CATTARAUGUS 6
ALLEGANY 2
STEUBEN 2
SCHUYLER 2
TOMPKINS 6
CHEMUNG 5
TIOGA 1
BROOME 20
DELAWARE 3
GREENE 2
COLUMBIA 0
ULSTER 7
DUTCHESS 22
SULLIVAN 2
ORANGE 31
PUTNAM 6
30
112
SUFFOLK 108
89
360
190
184
32
224

*Excluding residents, administrative, faculty, and inactive and retired obstreticians and gynecologists

SOURCE: NYS Education Department

PRACTICING PEDIATRICIANS*

1985


St. Lawrence 7
Franklin 2
Clinton 8
Essex 1
Jefferson 6
Lewis 0
2
Hamilton
Warren 6
Washington 5
Oswego 5
Oneida 16
Herkimer
Fulton 3
Saratoga 9
Niagara 15
Orleans 2
Monroe 82
5 Wayne
Genesee 2
Erie 91
Wyoming 1
Livingston 5
Ontario 8
Seneca 0
Yates 0
Cayuga 4
Onondaga 47
Madison 3
Montgomery 3
Schenectady 20
Albany 34
Rensselaer 9
Cortland 3
Chenango 2
Otsego 6
Schoharie 0
Tompkins 6
Schuyler 1
Greene 1
Columbia 3
Chautauqua 8
Cattaraugus 6
Allegany 0
Steuben 5
Chemung 8
Tioga 1
Broome 23
Delaware 3
Ulster 14
Dutchess 31
Sullivan 4
Orange 35
Putnam 8
8
46
Suffolk 148
211
340
256
211
367
56

NEW YORK STATE

COUNTIES

● = metropolitan counties

○ = rural counties

*Excluding residents, administrative, faculty, and inactive and retired pediatricians

SOURCE: NYS Education Department

HOSPITAL UTILIZATION

The following table of Admission Rates and Average Lengths of Stay for hospitals in rural counties in 1985, and the map of 1984 Discharge Rates, demonstrate that:

- Hospitals in the more rural types of counties had a greater rate of admissions than did hospitals in metropolitan counties. Some possible explanations for this difference include:
  - -- age distributions (i.e., a higher percentage of elderly persons, who have a greater need for acute care services, in rural areas);
  - -- a lack of service alternatives (i.e., rural patients in need of non-acute care utilize the hospital, for lack of availability of primary care services);
  - -- health status (i.e., rural residents often do not seek services until they are in need of much more acute care).
- Hospitals in rural counties also had shorter average lengths of stay than did hospitals in metropolitan counties. Possible reasons include:
  - -- the nature of care provided in rural hospitals (e.g., less specialized services, which require shorter lengths of stay, than are provided in metropolitan facilities);
  - -- the greater proportion of elderly persons in need of shorter-term acute care services;
  - -- migration patterns (i.e., rural residents in need of longer-term and more specialized acute care often migrate to metropolitan facilities for such services.

County Type		Admission Rate (Per 1000 Persons)	Length of Stay (Average Days)
	1	152.9	9.1
Metro	2	148.7	7.9
Rural	3	155.0	8.2
	4	170.5	7.5
	5	150.4	7.6
	6	184.9	7.3

Source: New York State Department of Health

Implications for Providers

- In many ways, discharging patients sooner saves on inpatient costs, since reimbursement is usually based on average costs per service.
- The hospital's role in providing non-acute care is gradually increasing, and presents an alternate method of generating revenue for the institution.
- As hospitals become more involved in such services, there is a greater need for different funding and reimbursement methods based on actual rural conditions.

Implications for Clients

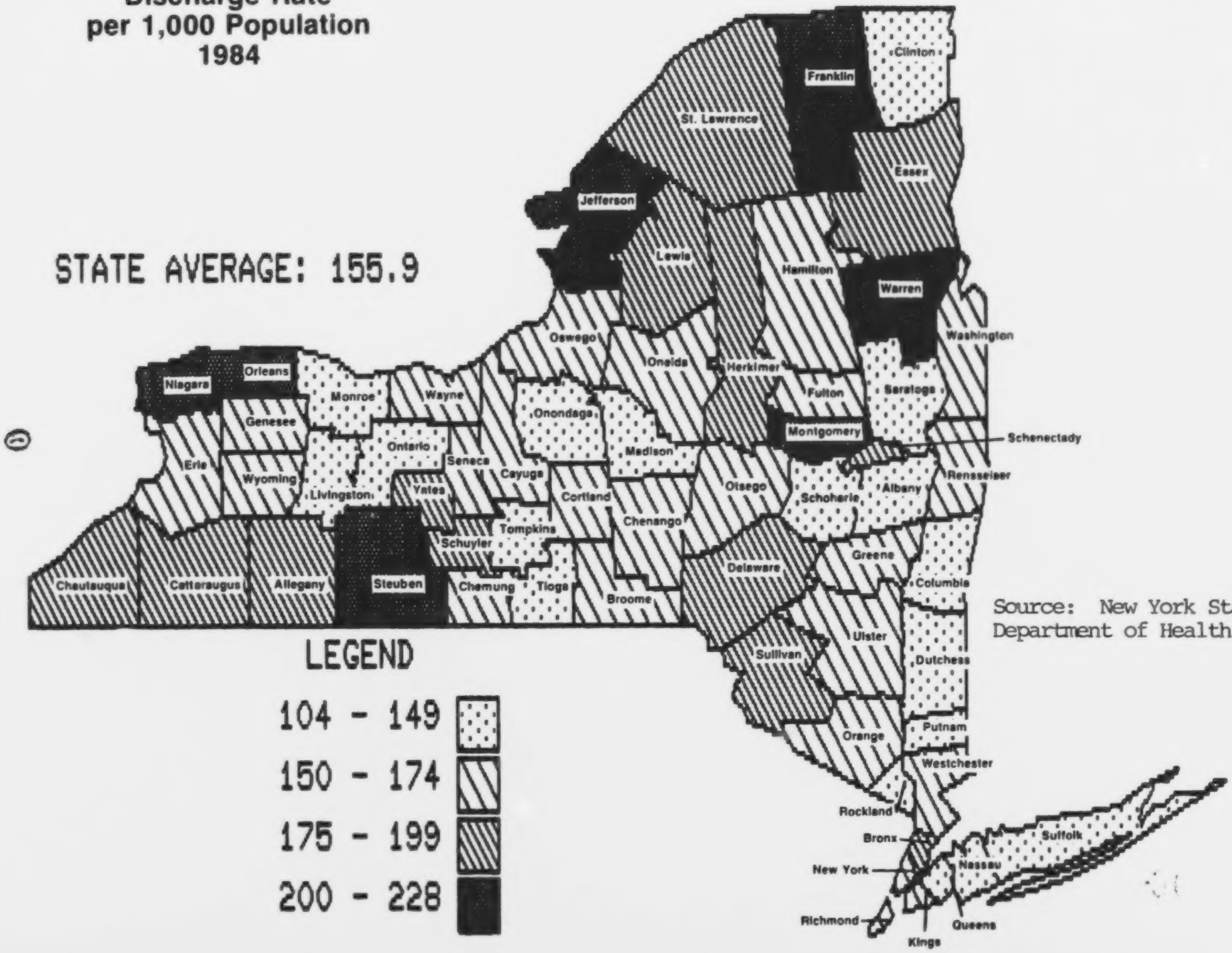
- As clients in rural areas are being discharged sooner, there is a greater need for skilled nursing/home health care.

  -- Nursing homes often have waiting lists, and restrict admittance to Medicaid and non-ambulatory patients, who are less profitable; thus, more non-institutional skilled nursing services are required in many rural areas.

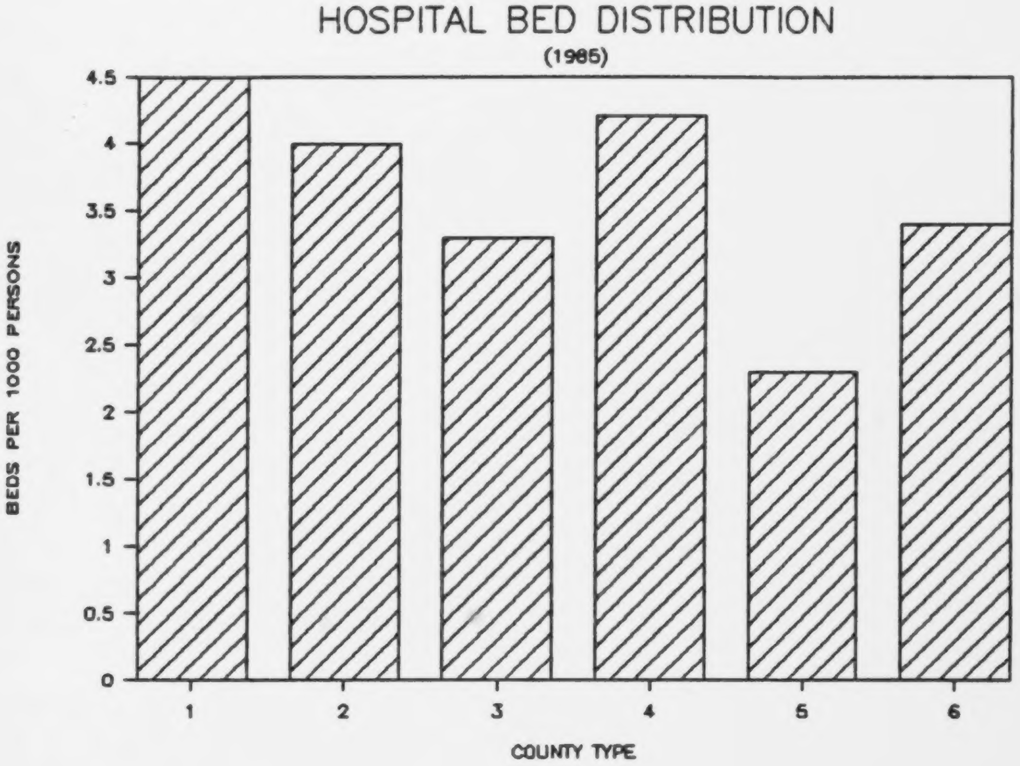
- Such clients also have greater need for discharge planning and case management, and such planning must be provided sooner (e.g., pre-admission discharge planning, when possible).

  -- This need assumes that a *choice* must be made sooner; but often rural residents *do not* have choices, because alternate levels and types of services are not available in every instance.

**Discharge Rate
per 1,000 Population
1984**


STATE AVERAGE: 155.9
Clinton
Franklin
St. Lawrence
Essex
Jefferson
Lewis
Hamilton
Warren
Washington
Oswego
Oneida
Herkimer
Fulton
Saratoga
Niagara
Orleans
Monroe
Wayne
Onondaga
Montgomery
Schenectady
Genesee
Erie
Wyoming
Ontario
Seneca
Cayuga
Madison
Livingston
Yates
Cortland
Otsego
Schoharie
Albany
Rensselaer
Chenango
Schuyler
Tompkins
Delaware
Greene
Columbia
Chautauqua
Cattaraugus
Allegany
Steuben
Chemung
Tioga
Broome
Ulster
Sullivan
Dutchess
Orange
Putnam
Westchester
Rockland
Bronx
New York
Richmond
Kings
Queens
Nassau
Suffolk
LEGEND
104 - 149
150 - 174
175 - 199
200 - 228

Source: New York State Department of Health



HOSPITAL BED DISTRIBUTION

(1985)

County Type		Hospital Beds per 1000 Persons
1	Metro	4.5
2		4.0
3	Rural	3.3
4		4.2
5		2.3
6		3.4

This graph of the distribution of hospital beds in the six county types shows that the average number of beds per one thousand persons is lower in rural than in urban counties. The one exception is county type 4, whose average number of beds is comparable to the most urban counties.

Source: New York State Department of Health

DISTRIBUTION OF HOSPITALS IN RURAL NYS COUNTIES
BY TOTAL NUMBER OF ACUTE BEDS
1986

COUNTY	NUMBER OF BEDS 1-25	26-50	51-75	76-100	101-125	126-150	151-175	176-200	200+	TOTAL HOSPITALS	COUNTY POPULATION (IN 000s)	COUNTY POPULATION DENSITY (PER SQ. MI.)
ALLEGANY		1			1					2	52	49
CATTARAUGUS			2		1		1			4	86	65
CAYUGA									1	1	80	115
CHAUTAUQUA		2			1		1		1	5	147	136
CHEMUNG									2	2	98	245
CHENANGO				1						1	49	55
CLINTON									1	1	81	76
COLUMBIA							1			1	59	92
CORTLAND								1		1	49	97
DELAWARE	1	3	1							5	47	33
ESSEX	1	2								3	36	20
FRANKLIN				2						2	45	27
FULTON			1		1					2	55	111
GENESEE				1	1					2	59	119
GREENE				1						1	41	63
HAMILTON										0	5	3
HERKIMER				1	1					2	67	47
JEFFERSON		2							2	4	88	68
LEWIS				1						1	25	18
LIVINGSTON				1						1	57	89
MADISON		1			1					2	65	99
MONTGOMERY					1		1			2	53	131
ONTARIO					1	2				3	89	137
ORLEANS		1	1							2	38	97
OSWEGO			1			1				2	114	118
OTSEGO					1			1		2	59	59
PUTNAM		1					1			2	77	334
RENSSELAER						1			2	3	152	229
SARATOGA		1						1		2	154	188
SCHENECTADY		1			1				2	4	150	724
SCHOHARIE			1							1	30	48
SCHUYLER		1								1	18	54
SENECA		1	1							2	34	102
ST. LAWRENCE	1	1		2	1					5	114	41
STEUBEN			1			1	1			3	99	70
SULLIVAN		1							1	2	65	67
TIOGA			1							1	50	95
TOMPKINS								1		1	87	181
ULSTER			1					1	1	3	158	139
WARREN									1	1	55	62
WASHINGTON	1		1							2	55	66
WAYNE			1				1			2	85	141
WYOMING					1					1	40	67
YATES			1							1	21	63
TOTALS	4	19	14	10	13	5	7	5	14	91	3,088	

HOSPITALS IN NEW YORK STATE'S RURAL COUNTIES
1983

	Number of Beds					
Rural Counties	Hospital	Nursing Home Type Units	Hospital Beds Per 10,000 Population	Obstetrics Available	Total Expend-itures (Thous. of Dollars	Total Number Personnel
Allegany	157	30	30	X	$11,455	481
Cattaraugus	390	-	45	X	25,094	1,055
Cayuga	294	-	37	X	10,456	752
Chautauqua	672	80	46	X	49,184	1,925
Chemung	527	71	54	X	62,826	2,224
Chenango	100	41	20	X	8,936	342
Clinton	376	54	47	X	28,084	1,026
Columbia	170	-	28	X	14,118	560
Cortland	177	-	36	X	14,101	533
Delaware	173	95	37	X	16,390	690
Essex	113	-	31	X	6,222(a)	306
Franklin	180	75	40	X	13,632	601
Fulton	177	-	32	X	17,085	667
Genesee	125	-	21	X	8,153	345
Greene	114	120	28	X	11,263	432
Hamilton(b)	-	-	-	-	-	-
Herkimer	269	34	40	X	13,493(a)	787
Jefferson	570	240	65	X	46,559	1,959
Lewis	76	120	78	X	8,966	400
Livingston	85	-	15	X	6,642	259
Madison	151	148	23	X	14,664	543
Montgomery	273	61	51	X	23,179	823
Ontario	270	82	30	X	29,864	1,114
Orleans	119	60	31	X	9,208	416
Oswego	269	-	24	X	6,117(a)	815
Otsego(d)	315	130	53	X	40,458	1,803
Putnam(b)	-	-	-	-	-	-
Rensselaer	654	19	43	X	40,943(a)	2,183
Saratoga	186	76	12	X	18,248	803
Schenectady	814	-	54	X	83,488	2,807
Schoharie	70	-	23	X	5,903	206
Schuyler	52	40	29	X	6,619	265
Seneca	116	33	34	-	6,534	279
St. Lawrence	389	29	34	X	29,117	1,206
Steuben	358	120	36	X	34,050	1,523
Sullivan	281	40	43	X	25,372	826
Tioga	67	80	13	-	(c)	222
Tompkins	191	-	22	X	18,672	677
Ulster	532	-	34	X	25,544	1,470
Warren	440	-	80	X	38,505	1,463
Washington	99	39	18	X	8,658	353
Wayne	214	44	25	X	17,376	678
Wyoming	108	72	27	X	10,737	398
Yates	62	24	29	-	4,456	189
SUMMARY:						
	10,895	1,937	35		$870,371	36,356

(a) One hospital did not report total expenditures and is not included here.
(b) No hospital in this county.
(c) The lone hospital in Tioga county did not report total expenditures.
(d) Otsego County figures include a teaching and research hospital in Cooperstown.

SOURCE: American Hospital Association Guide to the Health Care Field, 1983.

CLINICS

The availability of institutional ambulatory care (i.e., hospital outpatient services) is low in rural areas.

- In 1983, 114 out of 188 (60.6%) of the hospitals in urban counties operated ambulatory clinics. In the same year, 20 of 93 (21.5%) hospitals in rural counties had outpatient departments.
- Since hospital outpatient departments are a significant source of health care services for medically indigent persons in rural areas, this could severly hinder their access to services.
- This disparity may place additional financial burdens on those rural hospitals which do have outpatient departments, by requiring them to pick up a greater proportion of medically indigent persons.

While the number of Diagnostic & Treatment (D & T) Centers* in rural areas has increased since 1983, there are still fewer, and smaller, clinics in rural counties than in metropolitan counties.

- In 1983, 23 of the 96 (24%) multipurpose and child health freestanding clinics (the two most common types of D & T Centers) were located in rural counties.
- In 1986, 96 out of 299 (32%) of the state's total number of Diagnostic and Treatment Centers could be found in rural counties.
- In addition to providing health care to segments of the population which otherwise might not have access to such care, these diagnostic and treatment centers are often a viable alternative to institutional primary care services in areas where such services may not be available.

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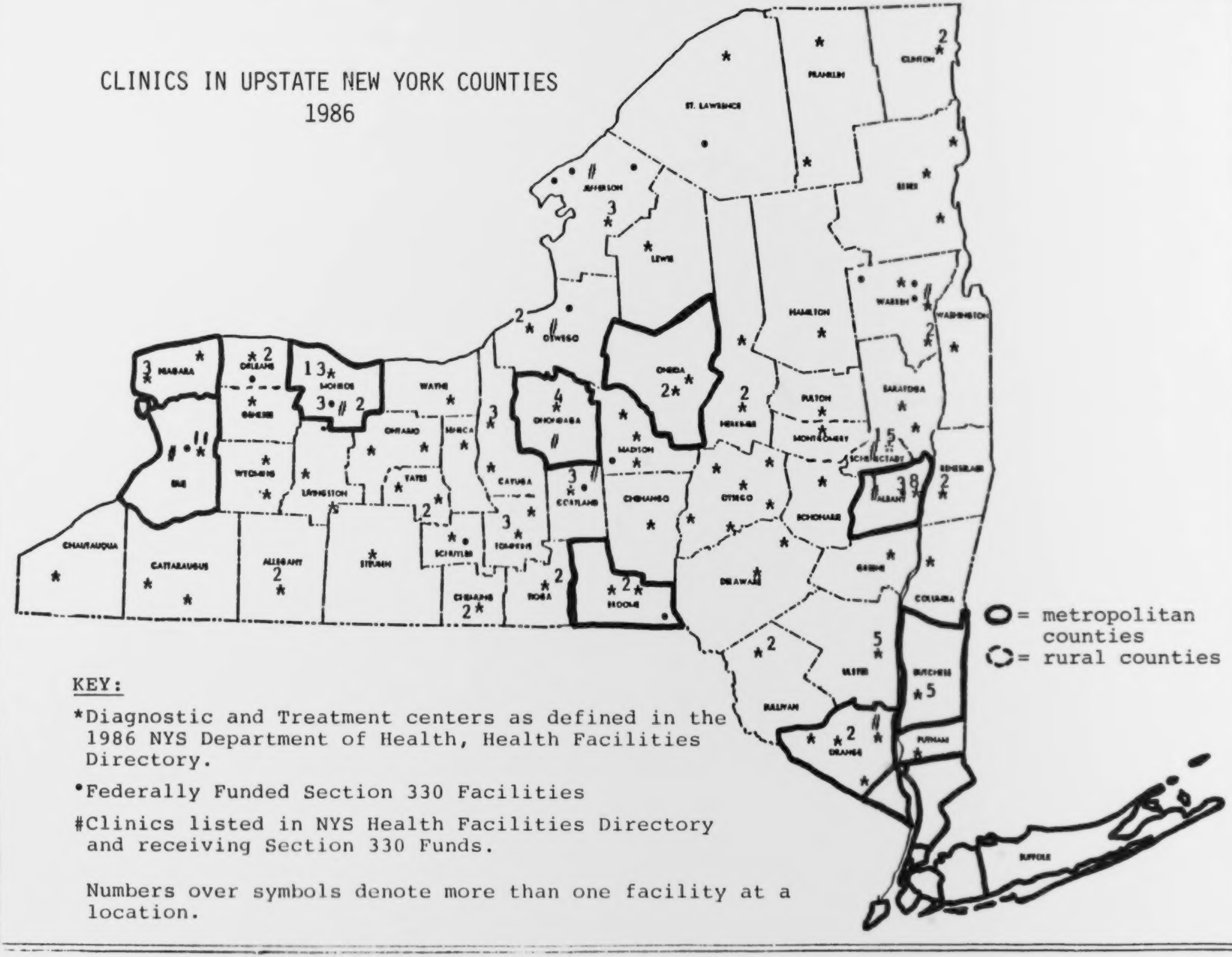
* Including multipurpose and child health clinics, as well as other single specialty clinics such as family planning/planned parenthood clinics, hemophilia clinics, speech and hearing centers, methadone maintenance treatment programs, abortion clinics, cerebral palsy and multiple sclerosis clinics, rehabilitation centers and renal dialysis centers.

The following two pages feature maps of: (1) Article 28 D & T Centers and Section 330 Clinics, and (2) Family Planning Clinics, in upstate New York counties.

CLINICS IN UPSTATE NEW YORK COUNTIES
1986


ST. LAWRENCE
FRANKLIN
CLINTON
ESSEX
JEFFERSON
LEWIS
HAMILTON
WARREN
WASHINGTON
OSWEGO
ONEIDA
HERKIMER
FULTON
SARATOGA
MONTGOMERY
SCHENECTADY
RENSSELAER
ALBANY
NIAGARA
ORLEANS
MONROE
WAYNE
GENESEE
ONONDAGA
MADISON
ONTARIO
SENECA
CAYUGA
ERIE
WYOMING
LIVINGSTON
YATES
CORTLAND
CHENANGO
OTSEGO
SCHOHARIE
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN
SCHUYLER
TOMPKINS
CHEMUNG
TIOGA
BROOME
DELAWARE
GREENE
COLUMBIA
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
SUFFOLK
○ = metropolitan counties
◌ = rural counties

KEY:

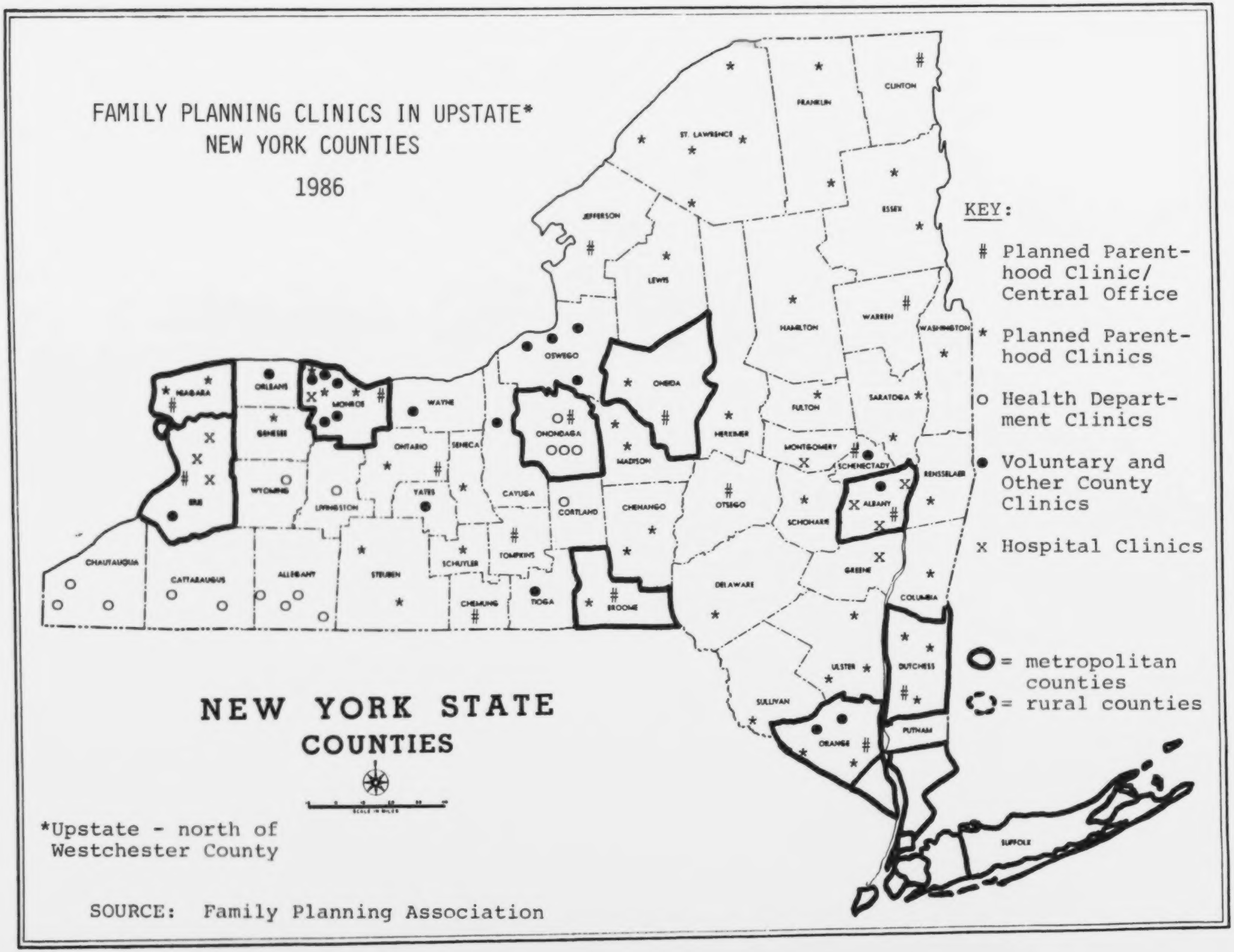
*Diagnostic and Treatment centers as defined in the 1986 NYS Department of Health, Health Facilities Directory.

•Federally Funded Section 330 Facilities

#Clinics listed in NYS Health Facilities Directory and receiving Section 330 Funds.

Numbers over symbols denote more than one facility at a location.

FAMILY PLANNING CLINICS IN UPSTATE* NEW YORK COUNTIES 1986


NEW YORK STATE
COUNTIES
ST. LAWRENCE
FRANKLIN
CLINTON
ESSEX
JEFFERSON
LEWIS
HAMILTON
WARREN
WASHINGTON
OSWEGO
ONEIDA
NIAGARA
ORLEANS
MONROE
WAYNE
ONONDAGA
HERKIMER
FULTON
SARATOGA
GENESEE
ONTARIO
SENECA
MONTGOMERY
SCHENECTADY
RENSSELAER
MADISON
ERIE
WYOMING
LIVINGSTON
YATES
CAYUGA
CORTLAND
CHENANGO
OTSEGO
SCHOHARIE
ALBANY
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN
SCHUYLER
TOMPKINS
CHEMUNG
TIOGA
BROOME
DELAWARE
GREENE
COLUMBIA
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
SUFFOLK
SCALE IN MILES

KEY:

# Planned Parenthood Clinic/ Central Office

* Planned Parenthood Clinics

o Health Department Clinics

● Voluntary and Other County Clinics

x Hospital Clinics

O = metropolitan counties

◌ = rural counties

*Upstate - north of Westchester County

SOURCE: Family Planning Association

EMERGENCY MEDICAL SERVICES

Certified Emergency Medical Technicians (Basic Level - 1985):

County Type		EMTs/1000 Persons	EMTs/Squad
	1	1.16	35.01
Metro	2	2.15	30.06
Rural	3	2.88	21.40
	4	2.84	15.59
	5	2.94	12.72
	6	3.27	9.49

Although the proportion of the population who are emergency medical technicians (EMTs) is much greater in rural areas than in urban areas, the average number of EMTs per squad is much lower in rural counties. Squads in rural communities tend to be smaller, as the area is more rural. Thus, the number of EMTs available to respond to an emergency call at any given time is less in these areas.

Ambulance Services (Certified and Registered - 1987):

County Type		EMS Units/ 10,000 Persons	Volunteer Units/ 10,000 Persons	Percent Volunteer Units
	1	0.32	0.23	69.71%
Metro	2	0.71	0.58	81.47
Rural	3	1.34	1.04	78.01
	4	1.80	1.54	85.64
	5	2.13	1.79	84.13
	6	3.51	3.20	91.07

The proportion of emergency medical services (EMS) units serving rural residents is much greater than in urban areas. Similarly, the proportion of EMS units that are staffed by volunteers increases greatly in the more rural county types. In rural areas squads are usually staffed by part-time members donating their time to responding to emergency calls, in addition to the hours invested in training. Futhermore, as the chart on the following page indicates, persons in rural areas have much less access to EMT training courses (both initial training and refresher courses) than do urban persons.

EMT Training Courses Offered (1985):

County Type		Average Number of Course Sponsors Per County	Average Number of Courses Offered Per County
	1	10	20.67
Metro	2	5	15.44
Rural	3	2	5.09
	4	2	4.33
	5	1	2.64
	6	2	3.00

Present 911 and Enhanced 911 Services (1987):

In addition, although the 911 system has been credited with decreasing response times, and increasing the overall efficiency of emergency medical services, only about 1.3% of the current 911 and Enhanced 911 access lines are located in rural counties of the state:

County Type		No. 911 Access Lines	% of Total
	1	5,886,000	86.4%
Metro	2	840,000	12.3
Rural	3	12,000	.2
	4	66,000	1.0
	5	0	0
	6	5,000	.1

Source: New York State Department of Health

LONG TERM CARE

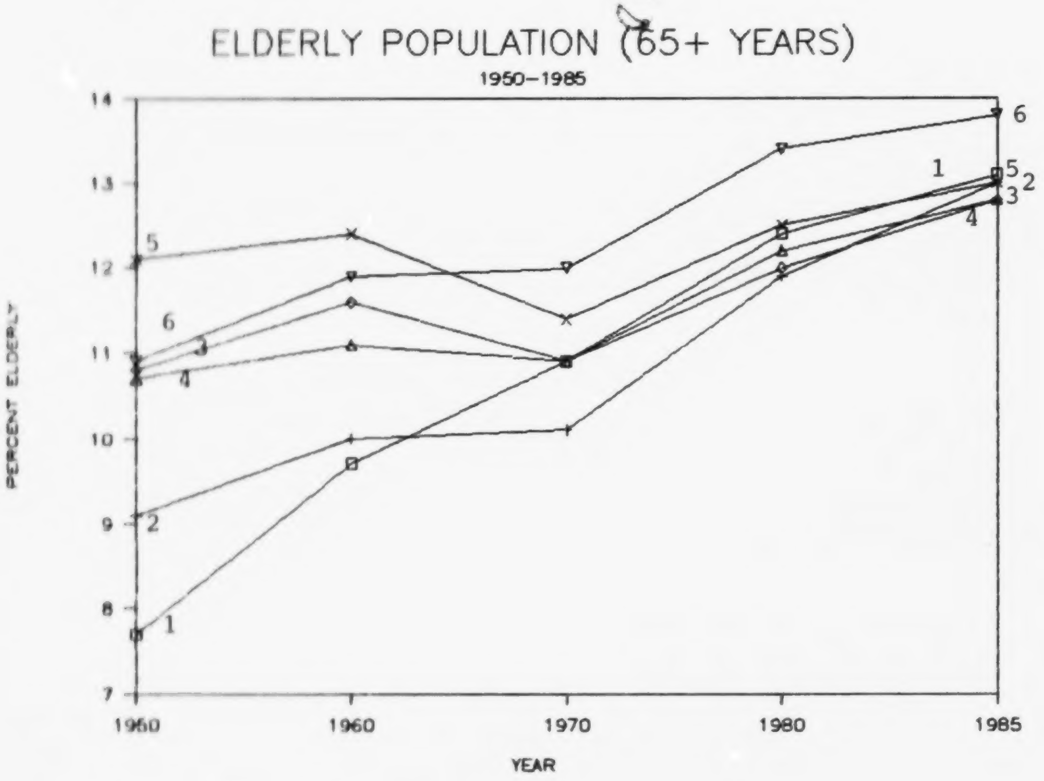
PERCENTAGE OF POPULATION 65+

County Type		1950	1960	1970	1980	1985
Metro	1	7.7	9.7	10.9	12.4	13.1
	2	9.1	10.0	10.1	11.9	13.0
Rural	3	10.8	11.6	10.9	12.0	12.8
	4	10.7	11.1	10.9	12.2	12.8
	5	12.1	12.4	11.4	12.5	13.0
	6	10.9	11.9	12.0	13.4	13.8

NURSING HOME (RHCF) BEDS
PER 1000 POPULATION 65+ (1985)

County Type	Number Beds
1	40.5
2	50.8
3	42.5
4	45.9
5	44.3
6	45.7

The distribution of nursing home (RHCF) beds is relatively consistent throughout all six county types. However, since the population of elderly persons is increasing for all areas, the need for long term care alternatives must be examined. While long term home health care (i.e., the Nursing Home Without Walls Program) shows promise for metropolitan areas, its practicality for rural areas is yet to be proven, particularly due to high staff travel costs. Currently, there are 28 Nursing Home Without Walls Programs located in rural counties of the state, and 61 in metropolitan counties.



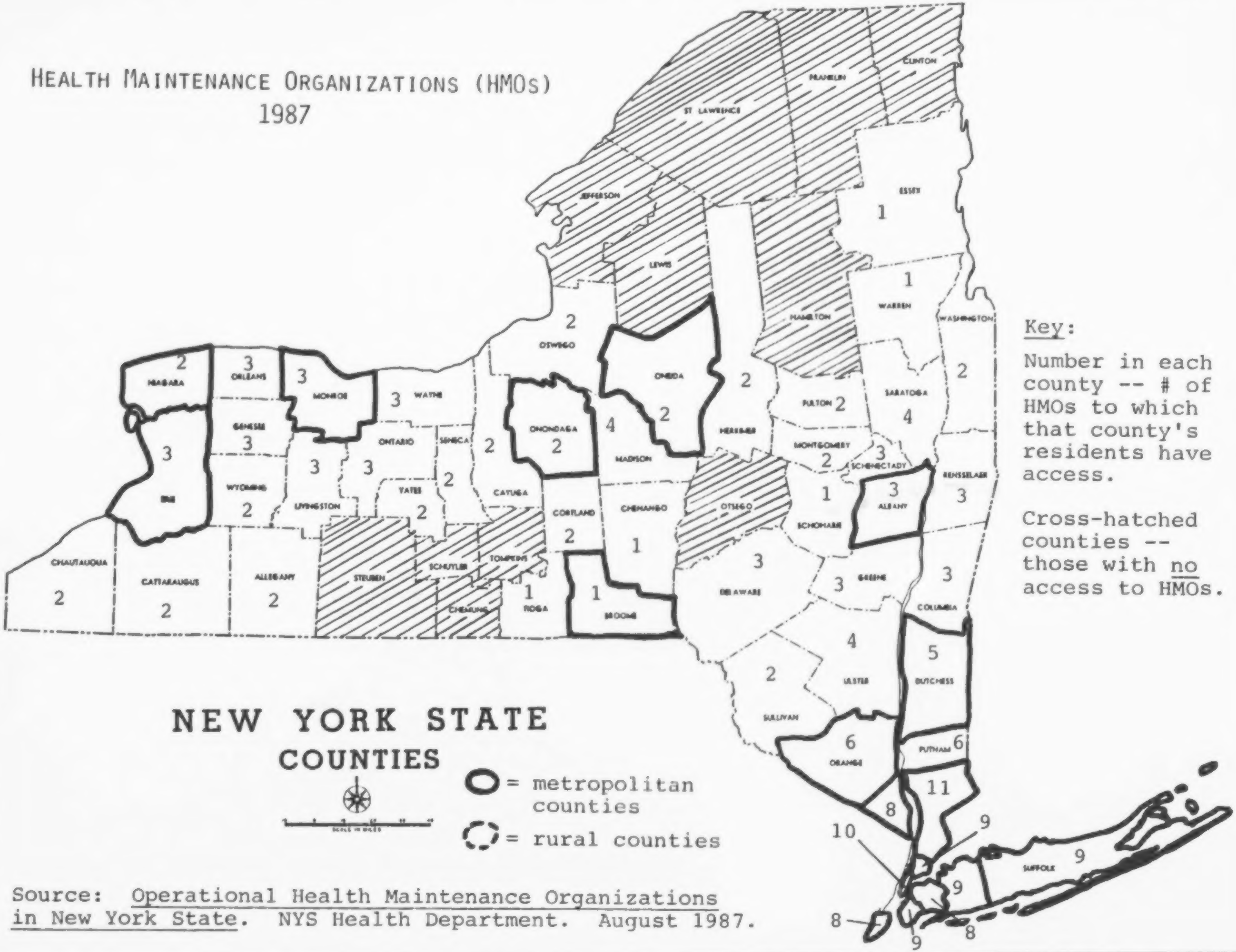
HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Health Maintenance Organizations (HMOs) are generally formed only in areas of 500,000 people or greater, in order to ensure the financial stability of the organization. However, recent years have seen growing numbers of HMOs in rural areas, as well as the expansion of metropolitan-based HMOs' service areas into rural areas.

The map on the following page shows the number of Health Maintenance Organizations serving each county in the state, as well as the counties which are not covered by any HMO. There are currently 28 HMOs throughout the state, with 17 having service areas either partially or fully encompassing one or more rural counties of the state. However, 11 of the 44 rural counties (25%) are not covered by any HMO service area, while residents of all of the metropolitan counties have access to at least one Health Maintenance Organization option.

In addition, all of the 33 rural counties that are covered by HMOs have access to at least one HMO which is an IPA or a network -- that is, those counties are located in the service area of at least one HMO that provides its services at more than one site.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)
1987


NEW YORK STATE
COUNTIES
SCALE IN MILES
Niagara 2
Orleans 3
Monroe 3
Wayne 3
Erie 3
Genesee 3
Wyoming 2
Livingston 3
Ontario 3
Yates 2
Seneca 2
Cayuga 2
Oswego 2
Onondaga 2
Oneida 2
Madison 4
Cortland 2
Chenango 1
Chautauqua 2
Cattaraugus 2
Allegany 2
Steuben
Schuyler
Chemung
Tompkins
Tioga 1
Broome 1
Jefferson
St Lawrence
Franklin
Clinton
Lewis
Hamilton
Otsego
Essex 1
Warren 1
Washington 2
Herkimer 2
Fulton 2
Saratoga 4
Montgomery 2
Schenectady 3
Schoharie 1
Albany 3
Rensselaer 3
Delaware 3
Greene 3
Columbia 3
Ulster 4
Dutchess 5
Sullivan 2
Orange 6
Putnam 6
11
8
10
9
9
8
9
8
Suffolk 9

○ = metropolitan counties

◌ = rural counties

Key:

Number in each county -- # of HMOs to which that county's residents have access.

Cross-hatched counties -- those with no access to HMOs.

Source: Operational Health Maintenance Organizations in New York State. NYS Health Department. August 1987.

HOSPITALS, NURSING HOMES, DIAGNOSTIC AND TREATMENT CENTERS AND SECTION 330 CLINICS IN UPSTATE NEW YORK COUNTIES

COUNTIES	HOSPITALS	RHCFs*	CLINICS	SECTION 330** FACILITIES
Albany	4	13	9	1
Allegany	2	4	2	0
Broome	3	10	3	1
Cattaraugus	4	6	2	0
Cayuga	1	4	4	0
Chautauqua	5	10	1	0
Chemung	2	6	2	0
Chenango	1	4	1	0
Clinton	1	7	2	0
Columbia	1	5	1	0
Cortland	1	2	2	2
Delaware	5	4	2	0
Dutchess	4	10	5	0
Erie	17	44	12	2
Essex	3	4	3	0
Franklin	2	3	2	0
Fulton	2	3	1	0
Genesee	2	4	1	0
Greene	1	2	1	0
Hamilton	0	1	1	1
Herkimer	2	5	3	0
Jefferson	4	5	4	4
Lewis	1	1	1	0
Livingston	1	4	2	0
Madison	2	4	3	2
Monroe	8	35	15	6
Montgomery	2	4	1	0
Niagara	5	13	4	0
Oneida	5	19	3	0
Onondaga	4	13	5	1
Ontario	3	6	2	0
Orange	7	7	6	0
Orleans	2	4	2	1
Oswego	3	6	3	2
Otsego	2	3	6	0
Putnam	2	1	1	0
Rensselaer	3	9	2	0
St. Lawrence	5	8	1	1
Saratoga	2	3	2	0
Schenectady	4	5	6	1
Schoharie	1	1	1	0
Schuyler	1	1	1	1
Seneca	2	2	1	0
Steuben	3	4	1	0
Sullivan	2	4	2	0
Tioga	1	3	2	0
Tompkins	1	4	4	0
Ulster	3	5	5	0
Warren	1	4	4	5
Washington	2	4	1	0
Wayne	2	4	1	0
Wyoming	1	3	2	0
Yates	1	2	3	0

*Residential Health Care Facilities (nursing homes)

**Receive funds from the US Department of Health and Human Services for the care of indigent patients in medically underserved areas.

Sources: 1986 New York State Department of Health, Health Facilities Directory; and US Department of Health and Human Services 1986 Directory of 330-Funded Community Health Centers.

REIMBURSEMENT

Most third party payors have different fee schedules for physicians' services to account for variability in costs in different geographic regions of the state. These third party payors include Medicare, Worker's Compensation and Blue Shield. Medicaid pays physicians' fees according to one statewide fee schedule.

Medicare

Reimbursement is on the basis of the physician's "reasonable charge" which is the lowest of:

1. The actual charge for the service provided;
2. The individual physician's median charge for similar services rendered during the previous year (the customary charge); or
3. The prevailing charge, which is the 75th percentile of all customary physician's charges made for similar services within that particular geographic region.

The actual payment to the physician is 80% of this reasonable charge (and the physician is entitled to collect the remaining 20% from the patient).

The geographic regions are: 1. Manhattan; 2. Queens; 3. Greater New York; 4. Northern Metropolitan Counties; 5. Buffalo area; 6. Rochester area; 7. Other upstate cities; and 8. Upstate rural.

Medicaid

Pays for physician services according to a single statewide fee schedule, based on the service provided. Physicians who treat Medicaid patients must accept those fees as payment in full for the services they provide.

Because Medicaid reimbursement payment for physician services is so low that the physician is in the position of subsidizing the cost of a recipient's health care, fewer doctors are accepting Medicaid patients.

In a comparison of New York State Medicaid to Medicare fees, Medicaid pays approximately 42 percent of what Medicare pays for general practitioners and approximately 24 percent of what Medicare pays for specialists. Nationwide, New York State ranks next to the bottom in the Medicaid/Medicare comparison for general practitioners and at the bottom for specialists.

Workers' Compensation

Is based on a regionalized fee schedule. Different relative value units are assigned to each procedure performed, and then a formula is applied to account for the differences in the type of medical expense and the geographic region. The overall fee schedule may result in cost differences of up to 30 percent in various parts of the state, reflecting differences in cost of living data and costs of running a medical practice.

The highest cost region includes New York City, Nassau and western Suffolk County. The other regions are: Northern metropolitan counties; Upstate urban areas; and Upstate rural areas.

Blue Shield

Also divides the state into regions and bases reimbursement on a profile of usual and customary fees for participating and non-participating doctors in the region. Reimbursement is limited to the 90th percentile of those fees.

As can be seen from these descriptions of third party reimbursement systems, the practice of reimbursing patients on a regional basis greatly contributes to the difficulties in delivering adequate rural health care. Oftentimes, the costs incurred in delivering services in rural localities (because of the absence of economies of scale, increased transportation needs, and fewer health care options), are equal to or greater than costs in metropolitan areas.

Source: Recommendations for Financing Ambulatory Care in Non-Hospital Settings. NYS Council on Health Care Financing, October 1983.

HEALTH CARE PERSONNEL

RECRUITMENT AND RETENTION

Inhibitory/discouraging factors involved include:

- Less educational, professional, social, and cultural opportunities in rural areas;
- Lower salaries and reimbursement rates for rural personnel and physicians;
- Higher malpractice rates for individual practicing physicians, (more frequent in rural areas), especially in high risk specialties;
- Less modern equipment in small, rural hospitals to attract new practitioners, and to retain them;
- Expenses encountered in recruiting physicians and personnel, often without positive results;
  - -- For example, one rural hospital is currently spending as much as $20,000 to $30,000 to recruit just one physician;
- Current trends in the health care system in general, such as the emphasis on specialty training, rapid growth of medical technology, licensing regulations, and practice constraints.

ROLES OF HEALTH CARE WORKERS

The roles and skills of health professionals and personnel in rural areas are quite different than in metropolitan areas.

- Physicians
  - -- Physicians in rural areas tend to be general, or inter-disciplinary, practitioners. Specialist practice is usually impractical, due to lack of economies of scale related to patient volume.

- Physician Extenders

  -- Physician extenders, such as physician's assistants and nurse practitioners, could serve a great function in rural areas by expanding the scope and size of an individual physician's practice. However, lack of recognition of their roles, as well as prohibitory laws and regulations, discourage them from assuming many duties that they may be (or could become) qualified to perform.

- Nursing Personnel

  -- Nurses and nurse aides in rural areas often serve a much different role than their urban-based counterparts. For example, an R.N. in a metropolitan hospital may be found in an administrative or supervisory position, whereas similar positions are not readily available in rural practices, because of small staffs. Also, rural nurses are likely to perform multidisciplinary technical-clinical patient services.

- Pharmacists

  -- In addition to dispensing drugs, a rural pharmacist has a variety of roles. Because he or she knows most residents personally, the pharmacist is a major source of medical and health-related information, and serves many times as an informal coordinator of care received by individual patients.

- Allied Health Personnel

  -- Other health personnel in rural areas also serve a variety of functions. With low patient volumes and diversity of health care needs being characteristic of rural health care, employees must be able to respond to such conditions by serving many different functions.

CERTIFICATION

Certification and licensure regulations and procedures drive the entire medical/health care personnel system, and generally reflect metropolitan practice and settings. Related factors which impede upon the efficiency and availability required of rural health delivery include:

- The trend toward rigid, single-specialty and even subspecialty practice, which does not accommodate the diverse needs of rural residents or clinical settings;

- The assumption that various support specialists and services are readily available and accessible in a rural medical practice.

- The lack of recognition and limitations imposed upon the practice of physician's extenders.

Medical practice in rural areas, in contrast to densely populated metropolitan areas, calls for more generalists and multidisciplinary practitioners, as well as medical support personnel who can greatly expand an individual physician's practice.

TRAINING

- Physician and medical professional training in general reflects urban settings, since that is usually where the teaching facilities are located (See map). Very little residency and internship programs occur in rural areas. Thus, a much greater percentage of physicians and professionals, such as therapists and other allied health personnel (including physician extenders) choose to continue practicing in metropolitan areas.

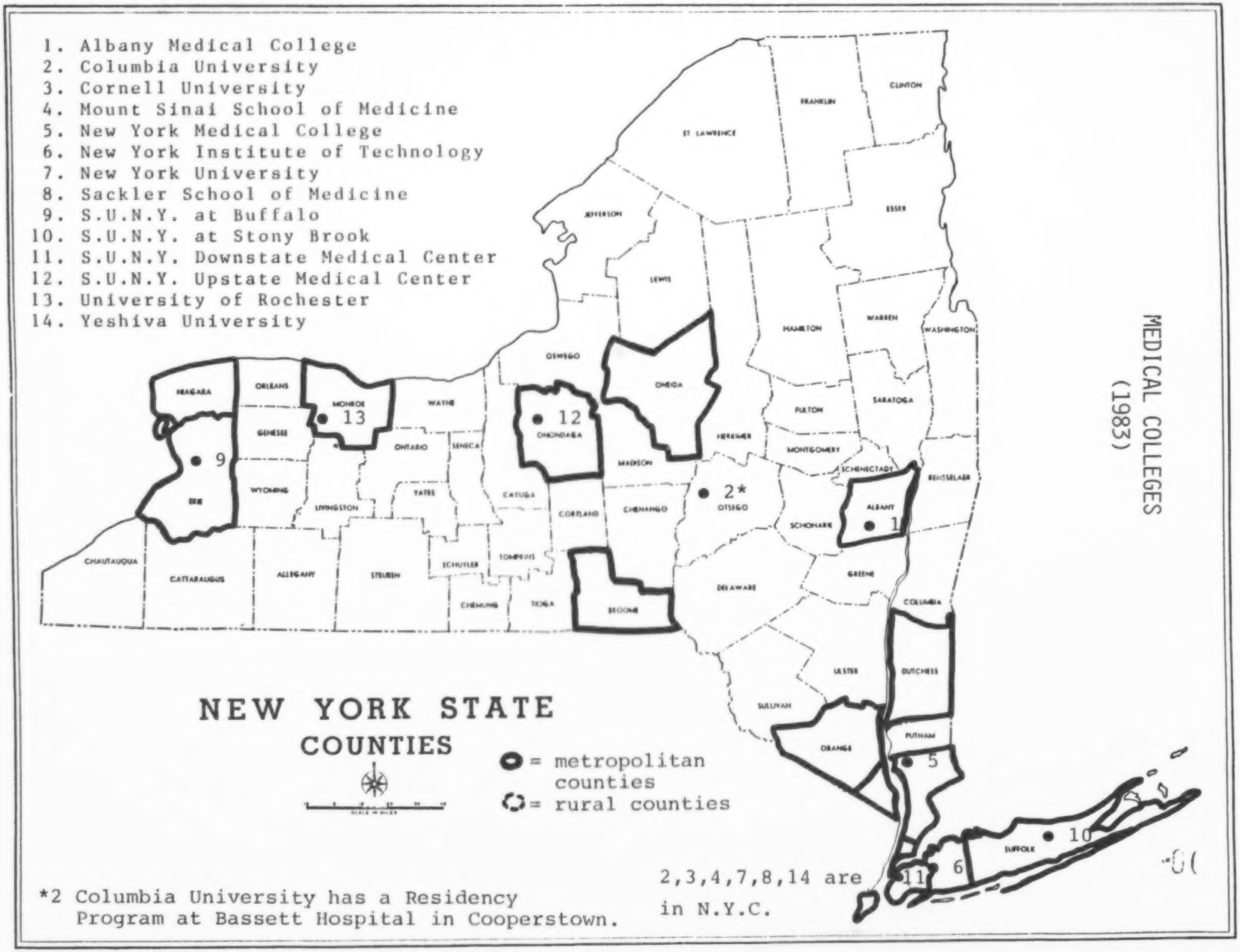
- Many nursing related training programs (for L.P.N.'s and R.N.'s, as well as nursing aides) are provided in SUNY Colleges and BOCES Districts (See maps). The following table shows the utilization pattern for R.N.'s and L.P.N.'s in 1980 for providers in metropolitan and rural counties of New York State.

NURSES PER 10,000 PERSONS (1980)

County Type		R.N.'s	L.P.N.'s
	1	85	32
Metro	2	108	81
Rural	3	92	52
	4	94	48
	5	85	43
	6	78	52

Source: "Are Nurses in Short Supply? A New York State Perspective." NYS Health Advisory Council. 1981.

MEDICAL COLLEGES (1983)


NIAGARA
ORLEANS
MONROE
13
WAYNE
GENESEE
9
ERIE
WYOMING
LIVINGSTON
ONTARIO
SENECA
YATES
CAYUGA
12
ONONDAGA
OSWEGO
JEFFERSON
LEWIS
ONEIDA
ST. LAWRENCE
FRANKLIN
CLINTON
ESSEX
HAMILTON
WARREN
WASHINGTON
HERKIMER
FULTON
SARATOGA
MONTGOMERY
SCHENECTADY
MADISON
CORTLAND
CHENANGO
2*
OTSEGO
ALBANY
1
RENSSELAER
SCHOHARIE
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN
SCHUYLER
TOMPKINS
CHEMUNG
TIOGA
BROOME
DELAWARE
GREENE
COLUMBIA
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
5
SUFFOLK
10
11
6
SCALE IN MILES

1. Albany Medical College
2. Columbia University
3. Cornell University
4. Mount Sinai School of Medicine
5. New York Medical College
6. New York Institute of Technology
7. New York University
8. Sackler School of Medicine
9. S.U.N.Y. at Buffalo
10. S.U.N.Y. at Stony Brook
11. S.U.N.Y. Downstate Medical Center
12. S.U.N.Y. Upstate Medical Center
13. University of Rochester
14. Yeshiva University

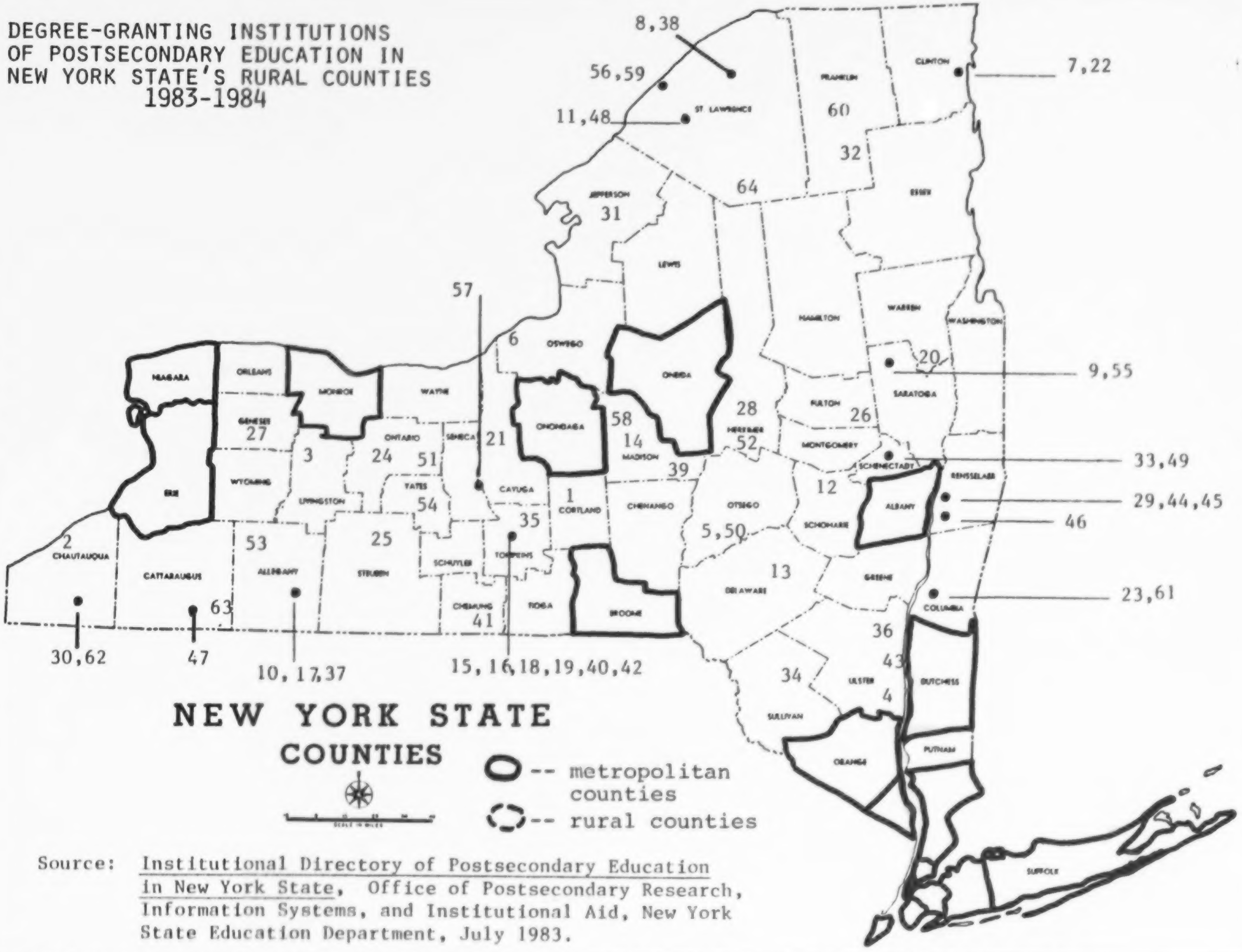
NEW YORK STATE
COUNTIES

● = metropolitan counties
○ = rural counties

2,3,4,7,8,14 are in N.Y.C.

*2 Columbia University has a Residency Program at Bassett Hospital in Cooperstown.

DEGREE-GRANTING INSTITUTIONS OF POSTSECONDARY EDUCATION IN NEW YORK STATE'S RURAL COUNTIES
1983-1984


NEW YORK STATE
COUNTIES
metropolitan counties
rural counties
8,38
56,59
11,48
7,22
ST LAWRENCE
FRANKLIN
CLINTON
60
32
64
ESSEX
JEFFERSON
31
LEWIS
HAMILTON
WARREN
WASHINGTON
57
6
OSWEGO
ONEIDA
20
SARATOGA
9,55
NIAGARA
ORLEANS
MONROE
WAYNE
ONONDAGA
58
14
MADISON
28
HERKIMER
52
FULTON
26
MONTGOMERY
SCHENECTADY
33,49
RENSSELAER
GENESEE
27
3
ONTARIO
24
51
SENECA
21
39
12
ALBANY
29,44,45
46
ERIE
WYOMING
LIVINGSTON
YATES
54
CAYUGA
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CORTLAND
CHENANGO
OTSEGO
SCHOHARIE
5,50
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2
CHAUTAUQUA
CATTARAUGUS
53
ALLEGANY
25
STEUBEN
SCHUYLER
TOMPKINS
13
DELAWARE
GREENE
COLUMBIA
23,61
63
CHEMUNG
41
TIOGA
BROOME
36
43
4
34
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
SUFFOLK
30,62
47
10, 17,37
15, 16,18,19,40,42

Source: Institutional Directory of Postsecondary Education in New York State, Office of Postsecondary Research, Information Systems, and Institutional Aid, New York State Education Department, July 1983.

DEGREE-GRANTING INSTITUTIONS OF POSTSECONDARY EDUCATION IN NEW YORK STATE'S RURAL COUNTIES (SEE MAP) 1983-84

State University of New York Colleges of Arts and Sciences - Baccalaureate, Post-Baccalaureate

1. State University College at Cortland
2. State University College at Fredonia
3. State University College at Geneseo
4. State University College at New Paltz
5. State University College at Oneonta
6. State University College at Oswego
7. State University College at Plattsburgh
8. State University College at Potsdam

State University of New York Colleges of Arts and Science - Baccalaureate

9. Empire State College - Saratoga Springs (Coordinating Center)*

State University of New York Agricultural and Technical Colleges - Certificate, Associate

10. Agricultural and Technical College at Alfred
11. Agricultural and Technical College at Canton
12. Agricultural and Technical College at Cobleskill
13. Agricultural and Technical College at Delhi
14. Agricultural and Technical College at Morrisville

State University of New York Statuatory Colleges - Post-Baccalaureate

15. College of Veterinary Medicine at Cornell University, Ithaca

State University of New York Statuatory Colleges - Baccalaureate, Post-Baccalaureate

16. College of Agriculture and Life Sciences at Cornell University, Ithaca
17. College of Ceramics at Alfred University*, Alfred
18. College of Human Ecology at Cornell University, Ithaca
19. School of Industrial and Labor Relations at Cornell University, Ithaca**

State University of New York Community Colleges - Certificate, Associate

20. Adirondack Community College at Glens Falls
21. Cayuga County Community College at Auburn
22. Clinton Community College at Plattsburgh
23. Columbia-Greene Community College at Hudson
24. Community College of the Finger Lakes at Canandaigua
25. Corning Community College at Corning
26. Fulton-Montgomery Community College at Johnstown
27. Genesee Community College at Batavia
28. Herkimer County Community College at Herkimer
29. Hudson Valley Community College at Troy
30. Jamestown Community College at Jamestown
31. Jefferson Community College at Watertown
32. North Country Community College at Saranac Lake***
33. Schenectady County Community College at Schenectady
34. Sullivan County Community College at Loch Sheldrake
35. Tompkins-Cortland Community College at Dryden
36. Ulster County Community College at Stone Ridge

Private Institutions - Baccalaureate, Post-Baccalaureate

37. Alfred University, Alfred**
38. Clarkson College of Technology, Potsdam
39. Colgate University, Hamilton
40. Cornell University, Ithaca
41. Elmira College, Elmira
42. Ithaca College, Ithaca
43. Mount Saint Alphonsus Seminary of Esopus
44. Rensselaer Polytechnic Institute, Troy
45. Russell Sage College, Troy
46. St. Anthony-on-Hudson, Rensselaer
47. St. Bonaventure University, St. Bonaventure
48. St. Lawrence University, Canton
49. Union University, Schenectady

* Also has Regional Centers with outreach services in: Alfred, Auburn, Canandaigua, Columbia-Greene, New Paltz, Fredonia, Plattsburgh, and Watertown.

** Degree program offered by these institutions at Corning Graduate Center, Corning.

*** Also has three branches in addition to main campus at Malone, Ticonderoga, and Elizabethtown.

Private Institutions - Baccalaureate

50. Hartwick College, Oneonta
51. Hobart and William Smith College, Geneva
52. Holy Trinity Orthodox Seminary, Jordanville
53. Houghton College, Houghton
54. Keuka College, Keuka Park
55. Skidmore College, Saratoga Springs
56. Wadhams Hall, Ogdensburg
57. Wells College, Aurora

Private Institutions - Associate, Certificate

58. Cazenovia College, Cazenovia
59. Mater Dei College, Ogdensburg
60. Paul Smith's College of Arts and Sciences, Paul Smiths

Private Institutions - Associate

61. Columbia Memorial Hospital School of Nursing, Hudson

Proprietary Institutions - Certificate, Associate

62. Jamestown Business College, Jamestown
63. Olean Business Institute, Olean

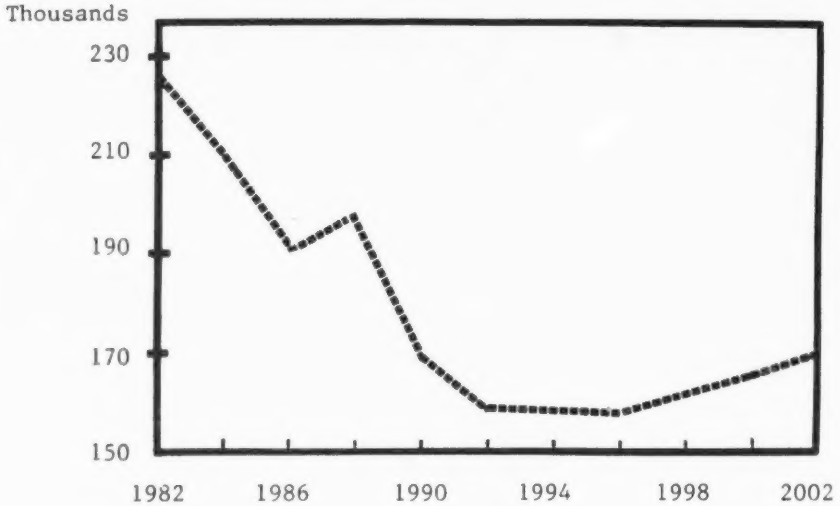
Metropolitan Institutions with Branch Campuses in Rural Counties

64. New York State Ranger School at Wanakena (College of Environmental Science and Forestry)

SOURCE: **Institutional Directory of Postsecondary Education New York State,** Office of Postsecondary Research, Information Systems, and Institutional Aid, New York State Education Department, July 1983.

PROJECTIONS OF HIGH SCHOOL GRADUATES IN PUBLIC AND NONPUBLIC SCHOOLS

NEW YORK STATE, 1982 TO 2002



Source: New York State Education Department, Information Center on Education.

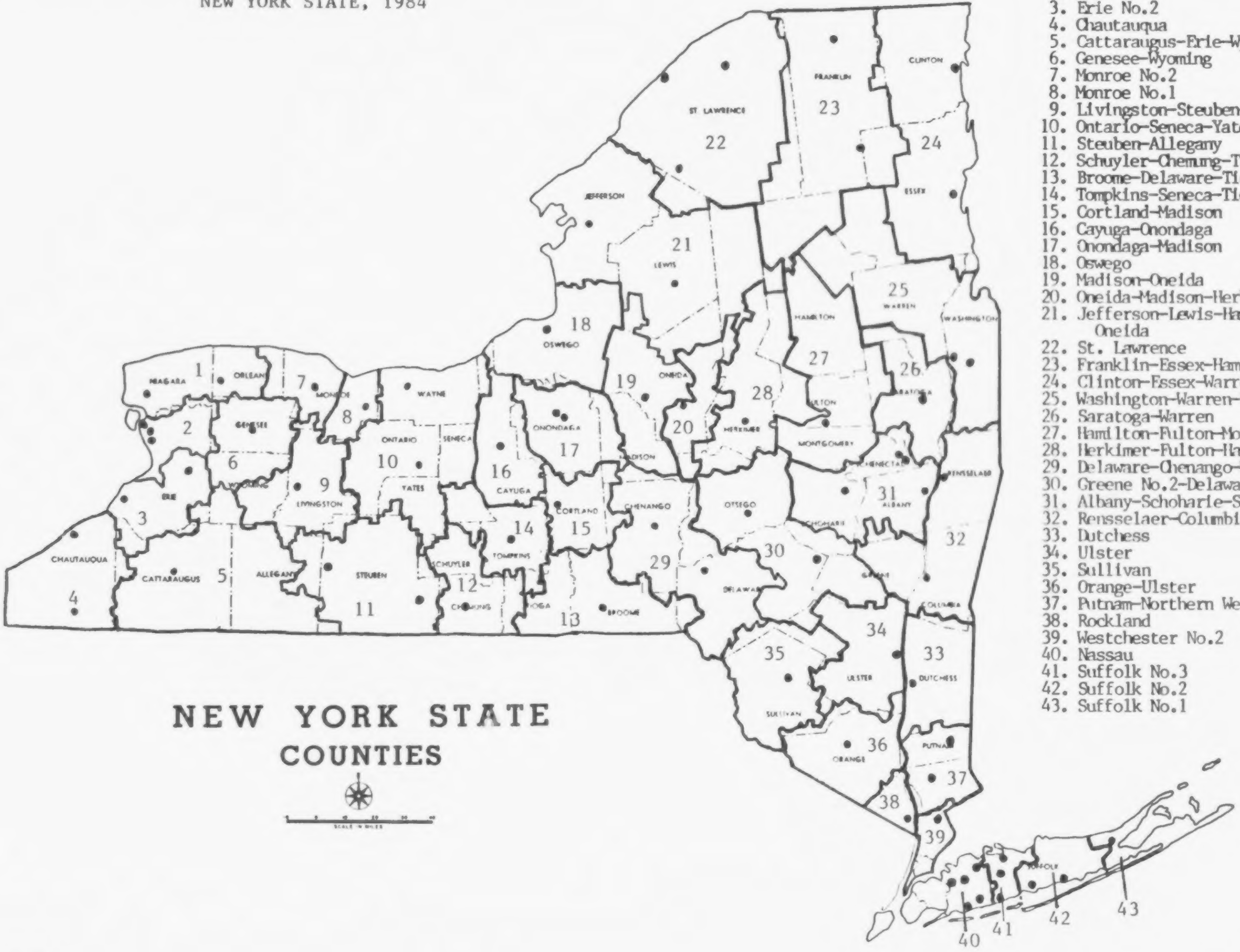
NUMBER OF INSTITUTIONS OFFERING UNDERGRADUATE AND GRADUATE PROGRAMS, BY MAJOR HEGIS AREAS* IN NEW YORK STATE'S RURAL AND METROPOLITAN COUNTIES, 1983

Major HEGIS AREA	Number of Institutions in Rural Counties	Number of Institutions in Metropolitan Counties	State Total
Agriculture and Natural Resources	3	4	7
Architecture and Environmental Design	4	14	18
Area Studies	14	38	52
Biological Sciences	28	72	100
Business and Management	21	65	86
Communications	8	32	40
Computer and Informaton Sciences	17	49	66
Education	26	70	96
Engineering	6	22	28
Fine and Applied Arts	24	65	89
Foreign Languages	23	60	83
Health Professions	17	64	81
Home Economics	6	14	20
Law	1	14	15
Letters	28	70	98
Library Science	1	8	9
Mathematics	27	69	96
Physical Sciences	26	66	92
Psychology	29	69	98
Public Affairs and Services	12	45	57
Social Sciences	29	75	104
Theology	5	18	23
Interdisciplinary Studies	26	61	87
Business and Commerce Technologies	30	91	121
Data Processing Technologies	22	61	83
Health Services and Paramedical Technologies	28	54	82
Mechanical and Engineering Technologies	22	31	53
Natural Science Technologies	17	22	39
Public Service Related Technologies	28	49	77
Pre-Baccalaureate Liberal Arts Programs	29	64	93

* **HEGIS** indicates the Higher Education General Informaton survey code, based on the Taxonomy of Instructional Programs in Higher Education (U.S. Office of Education) under which a program is registered by the New York State Education Department.

Source: **Inventory of Registered Degree and Certificate Programs** New York State Education Department, May 1981.

BOCES DISTRICTS AND OCCUPATIONAL EDUCATION CENTERS
NEW YORK STATE, 1984


NEW YORK STATE
COUNTIES
SCALE IN MILES
NIAGARA
ORLEANS
MONROE
WAYNE
GENESEE
ERIE
WYOMING
LIVINGSTON
ONTARIO
SENECA
YATES
CAYUGA
ONONDAGA
OSWEGO
JEFFERSON
ST LAWRENCE
FRANKLIN
CLINTON
ESSEX
LEWIS
HAMILTON
WARREN
WASHINGTON
ONEIDA
HERKIMER
MADISON
FULTON
SARATOGA
MONTGOMERY
SCHENECTADY
RENSSELAER
ALBANY
SCHOHARIE
OTSEGO
CHENANGO
CORTLAND
TOMPKINS
SCHUYLER
CHEMUNG
TIOGA
BROOME
DELAWARE
GREENE
COLUMBIA
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CATTARAUGUS
ALLEGANY
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SULLIVAN
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BOCES Districts:

1. Orleans-Niagara
2. Erie No.1
3. Erie No.2
4. Chautauqua
5. Cattaraugus-Erie-Wyoming
6. Genesee-Wyoming
7. Monroe No.2
8. Monroe No.1
9. Livingston-Steuben-Wyoming
10. Ontario-Seneca-Yates-Cayuga-Wayne
11. Steuben-Allegany
12. Schuyler-Chemung-Tioga
13. Broome-Delaware-Tioga
14. Tompkins-Seneca-Tioga
15. Cortland-Madison
16. Cayuga-Onondaga
17. Onondaga-Madison
18. Oswego
19. Madison-Oneida
20. Oneida-Madison-Herkimer
21. Jefferson-Lewis-Hamilton-Herkimer-Oneida
22. St. Lawrence
23. Franklin-Essex-Hamilton
24. Clinton-Essex-Warren-Washington
25. Washington-Warren-Hamilton-Essex
26. Saratoga-Warren
27. Hamilton-Fulton-Montgomery
28. Herkimer-Fulton-Hamilton-Otsego
29. Delaware-Chenango-Madison-Otsego
30. Greene No.2-Delaware-Schoharie-Otsego
31. Albany-Schoharie-Schenectady
32. Rensselaer-Columbia-Greene
33. Dutchess
34. Ulster
35. Sullivan
36. Orange-Ulster
37. Putnam-Northern Westchester
38. Rockland
39. Westchester No.2
40. Nassau
41. Suffolk No.3
42. Suffolk No.2
43. Suffolk No.1

NETWORKING AND COORDINATION

It has often been noted that health services in rural areas are unduly fragmented. Rural providers often plan and deliver their services in isolation, with little communication among health care providers, and virtually no communication between health care and human services providers. This results in an expensive system which is highly duplicative in terms of personnel, equipment, and support services. At a time when many rural health services providers are experiencing severe financial hardships, attempts at increasing cost-effectiveness are a necessity. This can be accomplished in a variety of ways, including:

- networking of state-local, public-private, and rural-urban partnerships;
- service delivery alternatives and innovations;
- greater sharing of information and resources among rural health care and human services providers;
- shared services and joint purchasing, for more efficient utilization of personnel and equipment;
- coordinated systems of care, particularly for underserved populations (e.g., elderly, disabled, and medically indigent persons);
- greater interaction of health care providers with other principal components of rural life and rural development;
- more representation on health policy-making entities at the state level.

DESIGNING AN INTEGRATED RURAL HEALTH SYSTEM

- Health Services Components
  - Major Services
  - Support Services
- Linking Services
  - Coordination and Networking
  - Transportation
  - Case Management
  - Public Education and Health Information

DESIGNING AN INTEGRATED RURAL HEALTH SYSTEM

An ideal rural health system would integrate the services now offered and support the development of services not yet available to citizens into a well-defined, comprehensive and financially viable health care network.

With this in mind, one must begin to consider how these services are now interacting, as well as how current trends will affect their relationships in the future, and how the evolution of an integrated system can be influenced.

The task of designing and influencing the development of an integrated rural health care system must be approached with specific goals, criteria, and characteristics in mind. Such a system should improve the quality and delivery of health services, as well as access to such delivery.

DESIGNING CLIENT HEALTH SERVICES COMPONENTS

Rural health care services in general can be divided into two categories: (1) major services, which for the most part already exist in some form in certain rural areas, and (2) other health and health-related services, which are not yet fully developed, but are nevertheless important for the health status and overall well-being of rural residents.

The following major health service components are those to which access is considered vital in any rural health care system:

Acute Care -- that part of the health care system concerned with the medical diagnosis and treatment of relatively short-term illness; and is usually divided into tertiary or secondary levels of care. Secondary level services include medicine, surgery, emergency medicine, obstetrics and pediatrics, as well as supportive diagnostic services such as radiology and laboratory services. Tertiary level services are highly specialized and usually require sophisticated technology and teams of specialists.

- Acute care services (particularly secondary level services) are generally provided in the rural hospital. Research in rural health has shown that 80-90 percent of patient medical needs can be handled satisfactorily by secondary-level facilities. There appears to be a growing need for a new intermediate level for acute care in rural areas. Such facilities may resemble an infirmary. A map and list of the 90 hospitals in rural counties of the state follows this section.
- Tertiary centers usually have a medical school or are directly affiliated with one for purposes of research residency training.

Primary Care -- the basic medical care provided at the point where the patient first comes in contact with the health care delivery system. It involves the services required to meet most general health needs and includes prevention, health maintenance, and continuing evaluation and management of general discomfort, early symptoms, and chronic intractable aspects of disease. There is a serious shortage of such services in rural areas, particularly for medically indigent persons.

- Primary care services are provided in many settings, but most often in either a diagnostic and treatment center (i.e., clinic) or in an individual practitioner's office.

Long Term Care -- services for persons who, because of a physical or mental condition, are unable to cope with the tasks of daily living without assistance for an extended period of time. Services range from assistance with simple activities of daily living to 24-hour-a-day nursing supervision and care, and may be provided in a variety of settings, including the patient's own home, out-patient facilities, and institutional environments.

- Institutional long-term care is generally provided in an Article 28 Residential Health Care Facility (Nursing Home). Although there are currently 238 such facilities in the 44 rural counties of the state, they do not adequately meet the needs of the growing population of elderly persons.

Home Care -- care provided in a non-institutional environment (usually the patient's own home). This type of care may include non-medical services, such as housing designed for disabled persons, home-delivered meals, or counseling, but which are often essential to the attainment of medically-directed care.

Elements of Care in the Home:

Skilled Nursing Care -- medically oriented care provided by a licensed nurse, including monitoring of acute and unstable chronic medical conditions, evaluation of the patient's care needs, injections, care of wounds and bed sores, tube feedings, and clearing of air passages. Skilled nursing care is usually authorized by a physician.

- Competition for qualified skilled nursing personnel is growing, and is especially difficult in rural areas.

Physical Therapy -- rehabilitative therapy provided by a qualified physical therapist.

Speech Therapy -- therapy provided by a qualified speech therapist to improve or restore speech.

Occupational Therapy -- therapy provided by a qualified occupational therapist to improve functional abilities.

High Tech Care -- equipment for services such as renal dialysis, respiratory therapy, and physical therapy are becoming more portable and thus can be provided in the home care environment.

Medical Social Services -- assessment, referral, and counseling services related to the medical care needs of the patient.

Home Health Aide Services -- assistance with simple, health-related tasks such as medications and exercises, and personal care services provided under the supervision of a licensed nurse.

Personal Care -- assistance with basic self-care activities such as bathing, dressing, getting out of bed, eating, and using the bathroom.

Homemaker Services -- household services such as cooking, cleaning, laundry, shopping, and escort services.

Chore Services -- household repairs, yard work, and errands.

Home-Delivered Meals -- meals delivered to the home for individuals who are unable to shop and/or cook for themselves.

Telephone Reassurance -- Regular telephone contact to individuals who are isolated and often homebound.

Home Health Care -- medically-prescribed care provided to people in their places of residence for the purpose of promoting, maintaining, or restoring physical and/or mental health, and for minimizing the effects of illness and disability.

- The staffing and provision of home health services is extremely difficult in rural areas.

Long Term Home Health Care (Nursing Home Without Walls) -- an alternative to institutional long term care, in that a comprehensive range of health, social, and environmental services is provided in the home for chronically ill or infirm persons. Services are coordinated by specifically designated hospitals, residential health care facilities, or certified home health agencies.

- There are currently 28 long-term home health care (i.e., Nursing Home Without Walls) programs in 27 of the 44 rural counties in New York State. Staffing is a major problem, especially in rural areas.

Rehabilitation -- restorative health services, such as physical and/or occupational therapy, provided following a major illness or accident, in a variety of settings including hospitals, health-related facilities, and the patient's home.

- The staffing and provision of rehabilitative services is extremely difficult in rural areas.

Emergency Medical Services -- services designed to facilitate initial entrance into the health care system for patients suffering from unanticipated, life-threatening illnesses or accident-related injuries. The emergency medical services system includes properly equipped transport vehicles, trained emergency attendants, properly staffed emergency departments to receive patients, and a central dispatch.

- The vast majority of first response emergency services in New York's rural areas are provided by volunteer squads. Recently, such squads have been experiencing increasing difficulties with the funding and staffing of their operations and regulatory structures.

In addition to the above major services, the rural health care delivery system should include availability of the following health-related and support components:

Day Care -- primarily social, but also including health promotion and maintenance services, for the elderly, children, and physically and/or mentally handicapped persons.

- Provision of such services in rural areas is often fragmented and poses many difficulties, especially due to a lack of economies of scale.

Respite -- a temporary support service available to in-home caregivers, allowing them a rest from the rigors and confinement of constant attention to the needs of infirm friends or relatives.

- There are few such services in rural areas.

Hospice -- care which recognizes the terminally ill patient's right to refuse major medical interventions, while being supportive in meeting needs of such individuals and family members arising from physical, psychological, spiritual, social, and economic stresses.

- Of the 16 hospices certified in NYS in 1986, 6 were located in the following rural counties: Chemung, Herkimer, Jefferson, Schenectady, St. Lawrence, and Tompkins.

Health Promotion/Illness Prevention -- educational, informational, and precautionary health services designed to increase the rural client's awareness and health status, in order to avoid illness or disease.

- Such services are not adequately and consistently provided in rural areas.

Mental Health Care -- both in- and out-patient services to meet the mental and emotional needs of rural clients.

- All 44 rural counties have county Mental Health Clinics and Departments. However, few community-based in-patient facilities are available.

Alcoholism and Substance Abuse Services -- either in- or out-patient care, provided to meet three primary goals: information and education for the benefit of the public; identification of persons who may have a problem; and intervention and treatment after a problem is identified.

- Few in-patient facilities are available in rural areas.

Dental Services -- services aimed primarily at preventive oral health and hygiene, in addition to restorative oral health and surgery, and referral services to other health specialists.

- Few dental clinics are available for the economically indigent in rural areas.

Related Human Services -- social, educational, and other services, including some described elsewhere, designed to meet the needs of rural residents which may affect their health status and/or access to health care.

Special Services -- other, ancillary services (e.g., pharmacy, laboratory) that may or may not be provided in the acute care hospital or ambulatory clinics, but are essential to providing access to the full continuum of health services.

- The delivery of pharmacy services is changing greatly in rural areas with the disappearance of the sole-proprietary druggist.

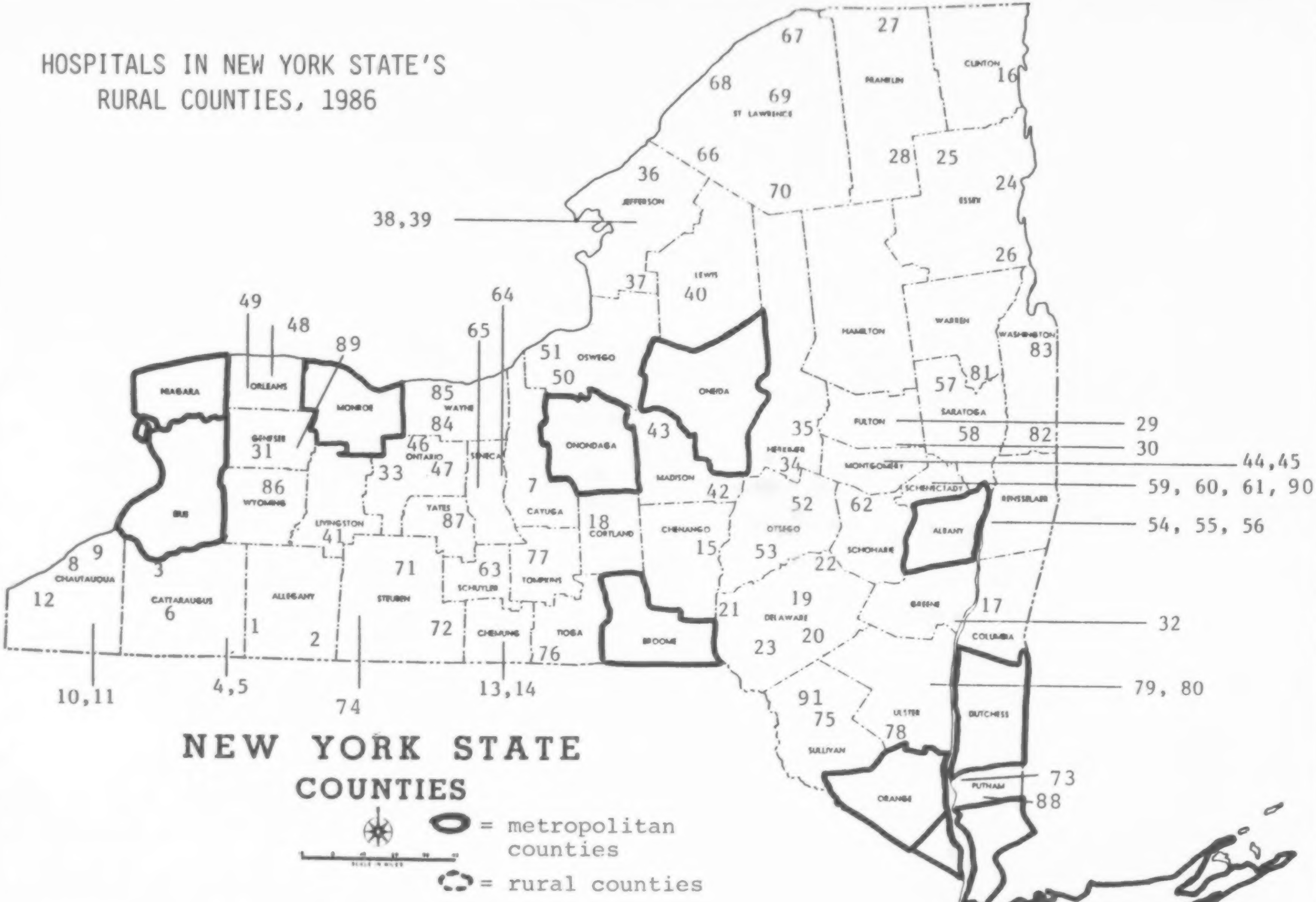
Environmental Health Services -- services designed to address those hygienic, sanitary or toxic aspects of personal and community health which may have adverse effects on the health and well-being of its residents.

- There are relatively few organized public health departments to deliver such services in rural areas.

Housing -- meeting the need for shelter of those rural persons at risk of being homeless or of living in inadequate homes, thus preventing many illnesses and diseases which could afflict the health of such persons. A map and list of Rural Preservation Companies (organizations existing to provide housing services in rural areas) can be found at the end of this section.

- There is a serious shortage of housing alternatives for the frail elderly and low-income groups in rural areas.

HOSPITALS IN NEW YORK STATE'S RURAL COUNTIES, 1986


NEW YORK STATE
COUNTIES
= metropolitan counties
= rural counties
ST LAWRENCE
FRANKLIN
CLINTON
ESSEX
JEFFERSON
LEWIS
HAMILTON
WARREN
WASHINGTON
SARATOGA
FULTON
HERKIMER
MONTGOMERY
SCHENECTADY
RENSSELAER
ALBANY
SCHOHARIE
OTSEGO
GREENE
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CORTLAND
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SENECA
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TOMPKINS
SCHUYLER
CHEMUNG
TIOGA
BROOME
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CATTARAUGUS
CHAUTAUQUA
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NIAGARA
ORLEANS
MONROE
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WYOMING
LIVINGSTON
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44,45
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59, 60, 61, 90
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54, 55, 56
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10,11
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75
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88

SOURCE: Health Facilities Directory 1986
New York State Department of Health

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HOSPITALS IN RURAL COUNTIES

(HOSPITAL BEDS BY TYPE OF SERVICE)

1986

	HOSPITAL NAME	COUNTY	M/S	ICU	CCU	PED	MATER	REHAB	PYSCH	INT	DETOX	TOTAL
						Type of Service*						
1	Cuba Memorial	Allegany	36	3	0	0	0	0	0	0	0	39
2	Jones Memorial	Allegany	81	2	4	8	7	0	0	0	0	102
3	Tri-County Memorial	Cattaraugus	50	3	0	0	8	0	0	0	0	61
4	Orlean General	Cattaraugus	118	8	0	13	14	0	0	0	0	153
5	St. Francis	Cattaraugus	76	3	2	10	10	0	10	0	0	111
6	Salamanca District Hospital	Cattaraugus	40	0	0	0	0	0	0	0	20	60
7	Auburn Memorial	Cayuga	202	10	10	10	20	0	14	0	0	266
8	Brooks Memorial	Chautauqua	128	5	5	10	14	0	0	0	0	162
9	Lake Shore Hospital	Chautauqua	41	3	0	0	0	0	0	0	0	44
10	Jamestown General	Chautauqua	88	3	3	0	0	0	13	0	0	107
11	Woman's Christian Association	Chautauqua	181	7	16	21	26	0	0	0	0	251
12	Westfield Memorial	Chautauqua	29	0	0	0	3	0	0	0	0	32
13	Arnot-Ogden Memorial	Chemung	175	0	17	20	32	0	0	12	0	256
14	St. Joseph's	Chemung	167	10	4	22	10	20	0	2	0	239
15	Chenango Memorial	Chenango	66	4	4	10	7	0	0	0	0	91
16	Champlain Valley Physicians	Clinton	265	14	7	23	25	0	22	0	0	356
17	Columbia Memorial	Columbia	136	8	0	14	12	0	0	0	0	170
18	Cortland Memorial	Cortland	123	12	0	16	15	0	11	0	0	177
19	A. Lindsay & Olive B. O'Connor	Delaware	30	0	0	0	0	0	0	0	0	30
20	Margaretville Memorial	Delaware	18	0	4	0	0	0	0	0	0	22
21	The Hospital (Sidney)	Delaware	51	5	0	0	5	0	0	0	0	61
22	Community (Stamford)	Delaware	27	0	2	0	3	0	0	0	0	32
23	Delaware Valley	Delaware	31	1	4	0	6	0	0	0	0	42
24	Elizabethtown Community	Essex	23	2	0	0	0	0	0	0	0	25
25	Placid Memorial	Essex	29	0	0	0	0	0	0	0	0	29
26	Moses-Ludington	Essex	41	0	0	0	4	0	0	0	0	45
27	Alice Hyde Memorial Hospital	Franklin	68	6	0	0	6	0	0	0	0	80
28	General Hospital of Saranac Lake	Franklin	74	3	4	3	7	0	0	0	0	91
29	Nathan Littauer	Fulton	94	6	0	14	10	0	0	0	0	124
30	Johnstown Hospital	Fulton	49	4	0	0	0	0	0	0	0	53
31	Genesee Memorial	Genesee	67	4	4	9	10	0	0	0	0	94
32	Memorial Hospital (Catskill)	Greene	70	6	0	5	4	0	0	0	0	85
33	F.F. Thompson	Ontario	101	7	0	0	13	0	0	0	0	121
34	Mohawk Valley General	Herkimer	72	0	0	4	7	0	0	0	0	83
35	Little Falls	Herkimer	99	3	4	4	6	0	0	0	0	116
36	E.J. Noble (Alex. Bay)	Jefferson	28	5	0	0	0	0	0	0	0	33
37	Carthage Area Hospital	Jefferson	38	0	0	4	6	0	0	0	0	48

HOSPITALS IN RURAL COUNTIES
(HOSPITAL BEDS BY TYPE OF SERVICE)
1986

	HOSPITAL NAME	COUNTY	M/S	ICU	CCU	PED	MATER	REHAB	PYSCH	INT	DETOX	TOTAL
			Type of Service									
38	House of the Good Samaritan	Jefferson	190	6	4	34	24	0	0	4	0	262
39	Mercy Hospital (Watertown)	Jefferson	131	6	4	27	24	0	30	0	0	222
40	Lewis County General	Lewis	64	0	0	6	6	0	0	0	0	76
41	Nicholas H. Noyes Memorial	Livingston	70	0	5	0	10	0	0	0	0	85
42	Community Memorial (Hamilton)	Madison	37	2	0	2	4	0	0	0	0	45
43	Oneida City Hospital	Madison	71	6	0	12	12	0	0	0	0	101
44	Amsterdam Memorial	Montgomery	87	6	4	11	7	0	0	0	0	115
45	St. Mary's (Amsterdam)	Montgomery	98	5	3	14	9	0	22	0	0	151
46	Clifton Springs	Ontario	120	0	0	0	0	0	18	0	0	138
47	Geneva General	Ontario	98	0	0	16	16	0	0	0	0	130
48	Arnold Gregory Memorial	Orleans	38	5	0	0	5	0	0	0	0	48
49	Medina Memorial	Orleans	54	6	0	5	6	0	0	0	0	71
50	Albert Lindley Lee Memorial	Oswego	63	2	2	0	0	0	0	0	0	67
51	Oswego Hospital	Oswego	92	4	4	12	20	0	0	0	0	132
52	Mary Imogene Bassett Hospital	Otsego	132	8	0	10	10	0	20	0	0	180
53	A.O. Fox Memorial	Otsego	99	4	4	11	7	0	0	0	0	125
54	Leonard Hospital	Rensselaer	114	9	0	0	0	0	0	0	20	143
55	Samaritan Hospital	Rensselaer	190	6	6	16	27	0	30	0	12	287
56	St Mary's (Troy)	Rensselaer	171	6	6	18	0	0	0	0	0	201
57	Adirondack Regional Hospital	Saratoga	30	0	0	0	0	0	0	0	0	30
58	Saratoga Hospital	Saratoga	125	7	7	12	15	0	16	0	0	182
59	Bellevue Maternity	Schenectady	0	0	0	0	40	0	0	0	0	40
60	Ellis Hospital	Schenectady	328	20	7	24	20	0	36	0	0	435
61	St. Clare's	Schenectady	211	10	10	15	19	0	0	0	0	265
62	Community (Cobleskill)	Schoharie	58	3	3	0	6	0	0	0	0	70
63	Schuyler Hospital	Schuyler	41	4	0	0	4	0	0	0	0	49
64	Seneca Falls	Seneca	36	0	0	14	0	0	0	0	0	50
65	Waterloo Memorial (Taylor Brown)	Seneca	54	2	0	0	0	0	0	0	0	56
66	E.J. Noble (Gouverneur)	St. Lawrence	37	3	0	3	4	0	0	0	0	47
67	Massena Memorial	St. Lawrence	62	2	2	8	5	0	0	0	0	79
68	A. Barton Hepburn Hospital	St. Lawrence	90	6	6	5	10	0	0	0	0	117
69	Canton-Potsdam Hospital	St. Lawrence	73	0	4	0	8	0	0	0	0	85
70	Clifton-Fine Hospital	St. Lawrence	20	0	0	0	0	0	0	0	0	20
71	Ira Davenport Memorial	Steuben	52	3	0	6	5	0	0	0	0	66
72	Corning Hospital	Steuben	119	8	4	17	10	0	0	0	0	158
73	Julia L. Butterfield Memorial	Putnam	32	0	0	0	4	0	0	0	0	36
74	St. James Mercy	Steuben	86	6	4	12	12	0	16	0	0	136
75	Community General (Harris)	Sullivan	209	13	10	18	12	0	13	0	16	291

HOSPITALS IN RURAL COUNTIES
(HOSPITAL BEDS BY TYPE OF SERVICE)
1986

	HOSPITAL NAME	COUNTY	M/S	ICU	CCU	PED	MATER	REHAB	PYSCH	INT	DETOX	TOTAL
						Type of Service						
76	Tioga General	Tioga	63	2	2	0	0	0	0	0	0	67
77	Tompkins Community	Tompkins	142	8	8	0	20	0	13	0	0	191
78	Ellenville Community	Ulster	55	0	0	4	0	0	0	0	0	59
79	Benedictine Hospital	Ulster	177	7	5	14	21	0	37	0	0	261
80	Kingston Hospital	Ulster	150	11	0	16	13	0	0	0	0	190
81	Glens Falls Hospital	Warren	321	16	12	34	27	0	30	0	0	440
82	Mary McClellan	Washington	64	3	2	0	5	0	0	0	0	74
83	Emma Laing Stevens	Washington	25	0	0	0	0	0	0	0	0	25
84	Newark-Wayne Community	Wayne	126	8	0	12	14	0	0	0	0	160
85	Myers Community	Wayne	44	2	2	0	6	0	0	0	0	54
86	Wyoming County Community	Wyoming	74	8	0	8	12	0	0	0	0	102
87	Soldiers & Sailors Memorial	Yates	58	4	0	0	0	0	0	0	0	62
88	Putnam Hospital Center	Putnam	122	0	10	10	14	0	0	0	0	156
89	St. Jerome	Genesee	89	3	5	9	0	0	0	0	0	106
90	Sunnyview Hospital	Schenectady	0	0	0	0	0	101	0	0	0	101
91	Community General (G. Herman)	Sullivan	30	0	0	0	0	0	0	0	0	30

*Type of Service

M/S--Medical/Surgical	MATER--Maternity
ICU--Intensive Care	MED REHAB--Medical Rehabilitation
CCU--Coronary Care	PSYCH--Psychiatric
PED--Pediatric	PED INT--Pediatric Intensive
	ALC DETOX--Alcohol Detoxification

HOSPITALS CLOSED IN RURAL COUNTIES, 1973 - 1986

Name of Facility	Location	County	Year
E.J. Barber Hospital	Lyons	Wayne	1973
Lyons Community Hospital	Lyons	Wayne	1973
E.J. Noble Hospital	Canton	St. Lawrence	1974
Will Rogers Hospital	North Elba	Essex	1975
Mercy Hospital	Auburn	Cayuga	1977
Community Hospital of Sullivan County - Liberty Division*	Liberty	Sulllivan	1977
Community Hospital of Sullivan County - Monticello Division*	Monticello	Sullivan	1977
Liberty Loomis Hospital	Liberty	Sullivan	1977
Keene Valley Hospital	Keene	Essex	1978
Benedict Memorial Hospital	Ballston Spa	Saratoga	1980
Read Memorial Hospital	Hancock	Delaware	1981
Hamilton Avenue Hospital	Monticello	Sullivan	1982
Mercy Hospital	Tupper Lake	Franklin	1983
Herkimer Memorial Hospital	Herkimer	Herkimer	1984
Bethesda Hospital	Hornell	Steuben	1986

* Merged to form Community General Hospital of Sullivan County, located in Harris, New York.

Source: NYS Department of Health

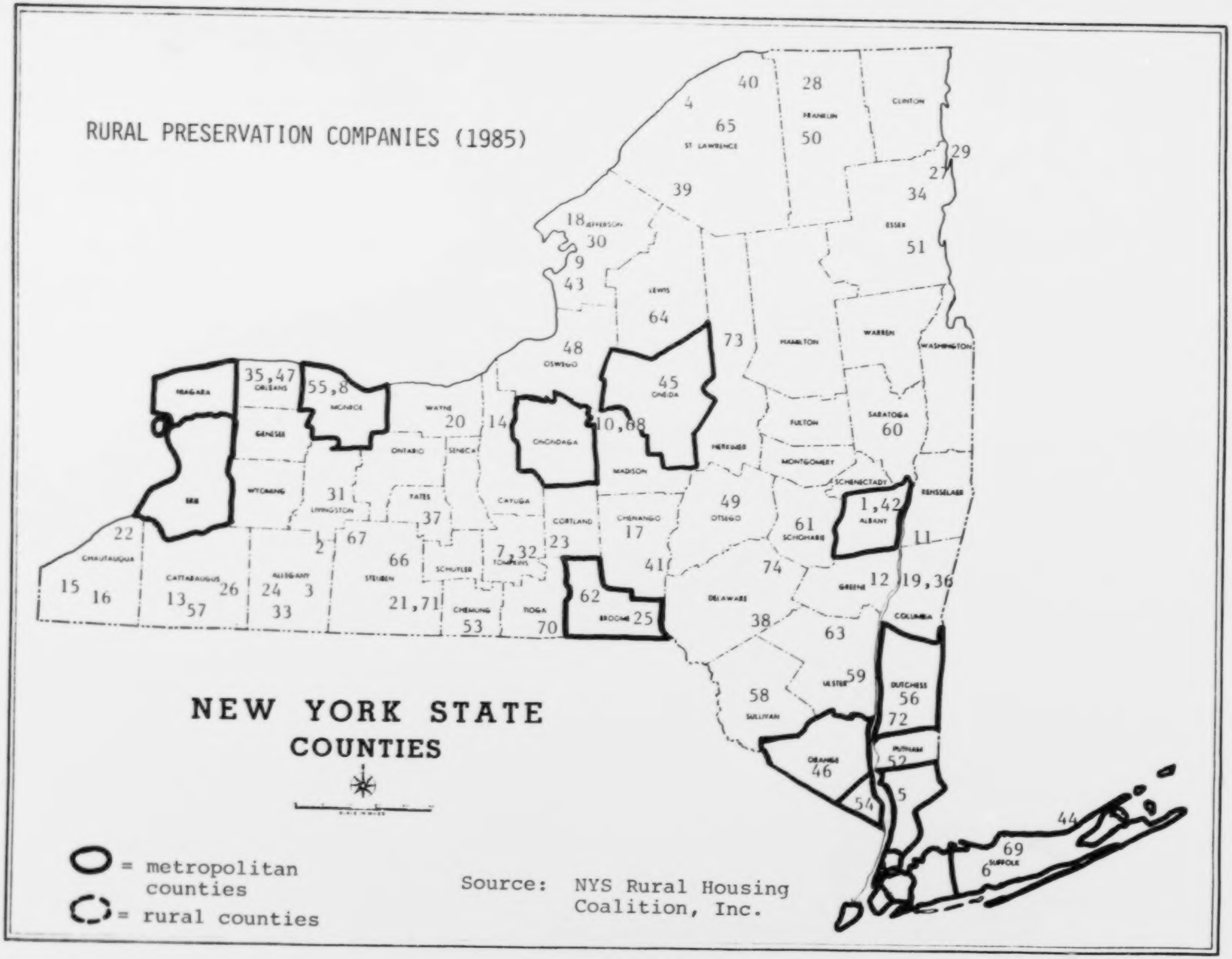
RURAL PRESERVATION COMPANIES IN NEW YORK STATE (1985)

Rural Preservation Companies are nonprofit community-based organizations which contract with the New York State Division of Housing and Community Renewal to provide housing services in rural areas of the state pursuant to Article XVII of the Private Housing Finance Law.

NUMBER	RURAL PRESERVATION COMPANY	COUNTY
1	Albany County Rural Housing Alliance	Albany
2	Alfred Housing Committee	Allegany
3	Andover Historic Preservation Corp.	Allegany
4	Assoc. for Neighborhood Rehab. Inc.	St. Lawrence
5	Assoc. for Improvement in Mohegan	Westchester
6	Bellport, Hagerman, East Patchogue Alliance	Suffolk
7	Better Housing for Tompkins County	Tompkins
8	Bishop Sheen Ecumenical Housing Foundation	Monroe
9	Black River Housing Council	Jefferson
10	Canastota Canal Town Corp.	Madison
11	Castleton-on-Hudson Neighborhood Assoc.	Rensselaer
12	Catskill Mountain Housing Development Corp.	Greene
13	Cattaraugus County Neighborhood Preservation Co.	Cattaraugus
14	Cayuga Developments, Inc.	Cayuga
15	Chautauqua Home Rehabilitation & Improvement Corp.	Chautauqua
16	Chautauqua Opportunities	Chautauqua
17	Chenango Housing Improvement Program, Inc.	Chenango
18	Clayton Improvement Association, Ltd.	Jefferson
19	Columbia Preservation Corp.	Columbia
20	Community Action in Self Help	Wayne
21	Community Progress, Inc.	Steuben
22	Core Area Preservation Company, Inc.	Chautauqua
23	Cortland Housing Assistance Council, Inc.	Cortland
24	Cuba Community Development Corporation	Allegany
25	Deposit-Sanford Rural Housing Council	Broome
26	Eastside Neighborhood Org. for Dev. Inc.	Cattaraugus
27	Essex Community Heritage Organization	Essex
28	Franklin County Community Housing Council, Inc.	Franklin
29	Friends of Keeseville, Inc.	Essex
30	Frontier Housing Corporation	Jefferson
31	Genesee Valley Rural Preservation Council	Livingston
32	Historic Ithaca and Tompkins County, Inc.	Tompkins
33	Housing Action Corporation	Allegany
34	Housing Assistance Program of Essex County	Essex
35	Housing Development Council of Orleans County	Orleans
36	Hudson Housing Services Corporation	Columbia
37	Keuka Housing Council, Inc.	Yates
38	M-Ark Project, Inc.	Delaware
39	Marble City Housing Corporation	St. Lawrence
40	Mohawk Indian Housing Corp.	St. Lawrence
41	New Berlin Housing and Preservation Co.	Chenango
42	New York State Rural Housing Coalition, Inc.	Albany
43	North Shore Preservation Company	Jefferson

44	North Fork Housing Alliance, Inc.	Suffolk
45	Oneida County Community Action Agency	Oneida
46	Orange County Rural Development Advisory Corp.	Orange
47	Orleans/Genesee Rural Preservation Corp.	Orleans
48	Oswego Housing Development Council	Oswego
49	Otsego Rural Housing Assistance, Inc.	Otsego
50	Preservation Enterprises	Franklin
51	PRIDE of Ticonderoga Rural Preservation Co.	Essex
52	Putnam County Housing Corp.	Putnam
53	Regional Housing Council of the Southern Tier	Chemung
54	Rockland County Community Development Council	Rockland
55	Rural Opportunities, Inc.	Monroe
56	Rural Preservation Company of Dutchess County, Inc.	Dutchess
57	Rural Revitalization Corporation	Cattaraugus
58	Rural Sullivan County Housing Opportunities	Sullivan
59	Rural Ulster Preservation Company	Ulster
60	Saratoga County Rural Preservation	Saratoga
61	Schoharie County Rural Preservation	Schoharie
62	Secretariat for Education and Project Planning	Broome
63	Sharp Committee, Inc.	Ulster
64	Snow Belt Housing Company	Lewis
65	St. Lawrence County Housing Council	St. Lawrence
66	Steuben Churchpeople Against Poverty, Inc.	Steuben
67	Steuben-Livingston Agricultural Project, Inc.	Steuben
68	Stoneleigh Housing, Inc.	Madison
69	Suffolk Community Development Corporation	Suffolk
70	Tioga Opportunities Program, Inc.	Tioga
71	Tri-County Action Council	Steuben
72	Wappingers Falls Youth Outreach/Comm. Serv. Program	Dutchess
73	Warren-Hamilton Housing Corporation	Herkimer
74	Western Catskills Comm. Revitalization Corp.	Delaware

Source: Rural Housing Resource Book. New York State Rural Housing Coalition, Inc.


RURAL PRESERVATION COMPANIES (1985)
NEW YORK STATE
COUNTIES
= metropolitan counties
= rural counties
NIAGARA
ERIE
ORLEANS
35,47
GENESEE
WYOMING
MONROE
55,8
WAYNE
20
ONTARIO
SENECA
14
LIVINGSTON
31
YATES
37
CAYUGA
ONONDAGA
OSWEGO
48
JEFFERSON
18
30
9
43
ST LAWRENCE
40
4
65
39
FRANKLIN
28
50
CLINTON
29
27
ESSEX
34
51
LEWIS
64
ONEIDA
45
10,68
MADISON
HERKIMER
73
HAMILTON
WARREN
WASHINGTON
FULTON
SARATOGA
60
MONTGOMERY
SCHENECTADY
ALBANY
1,42
RENSSELAER
11
OTSEGO
49
SCHOHARIE
61
CORTLAND
23
CHENANGO
17
41
TOMPKINS
7,32
SCHUYLER
STEUBEN
67
66
21,71
CHEMUNG
53
TIOGA
70
BROOME
62
25
CHAUTAUQUA
22
15
16
CATTARAUGUS
13
57
26
ALLEGANY
2
24
3
33
DELAWARE
74
38
GREENE
12
COLUMBIA
19,36
63
ULSTER
59
SULLIVAN
58
DUTCHESS
56
72
ORANGE
46
PUTNAM
52
54
5
44
SUFFOLK
69
6

Source: NYS Rural Housing Coalition, Inc.

LINKING SERVICES

The field of health services delivery may be thought of as a social system which exists along with other social systems (e.g., government, economic, religious, and family systems). The health care delivery system, like other social systems, attempts to meet certain needs of society. Included in the overall health services delivery system are several subsystems or linking functions: Transportation, Coordination and Networking, Case Management, Education, Information and Resource Centers. In order to have a health care delivery system in a rural area which meets the needs of the community, these linking services must be available and organized to function effectively.

Coordination and Networking

There is a growing trend among rural hospitals to share services such as purchasing, laundry, billing, microfilming of medical records, biomedical testing, radiotherapy, continuing education, architectural design, and pastoral counseling. There are four common types of sharing structures:

- A single hospital reaches out to provide services to a group of smaller institutions.
- A state hospital association establishes a nonprofit corporation to develop services and sell them to hospitals.
- An organization, such as certain orders in the Catholic hospitals, develops a shared services program.
- A freestanding corporation is established to develop shared services.

The variety of possible shared services or joint operations provides a number of alternatives for rural communities. Economy and enhanced services are the most obvious advantages of shared services, and may even be, for a struggling hospital, its last hope of survival. In addition, improved quality of care often results from such cooperative arrangements. By cooperating, small hospitals can offer their patients a much wider range of services, as well as increased access to specialists and expensive equipment. Management skills and training resources can be shared as well, to help hospitals function efficiently and meet various certification and legal requirements.

Attention and support for such arrangements by both the public and private sectors have recently increased. For example, the Governor and the State Legislature have recognized the advantages of joint ventures and networking for rural health providers by the passage in 1986 of a bill sponsored by the

Commission on Rural Resources. The new law provides a grant program and technical assistance for such ventures. In addition, the Kellogg Foundation and the Robert Wood Johnson Foundation have developed special grant programs for rural hospitals tht promote cooperative efforts. (A briefing paper on alternatives for cooperative efforts in rural health care delivery is available at the Commission office.)

Transportation

Transportation, as related to health care, takes two major forms: transportation for emergencies and transportation for accessing other types of health services.

1. Emergency Transportation Services

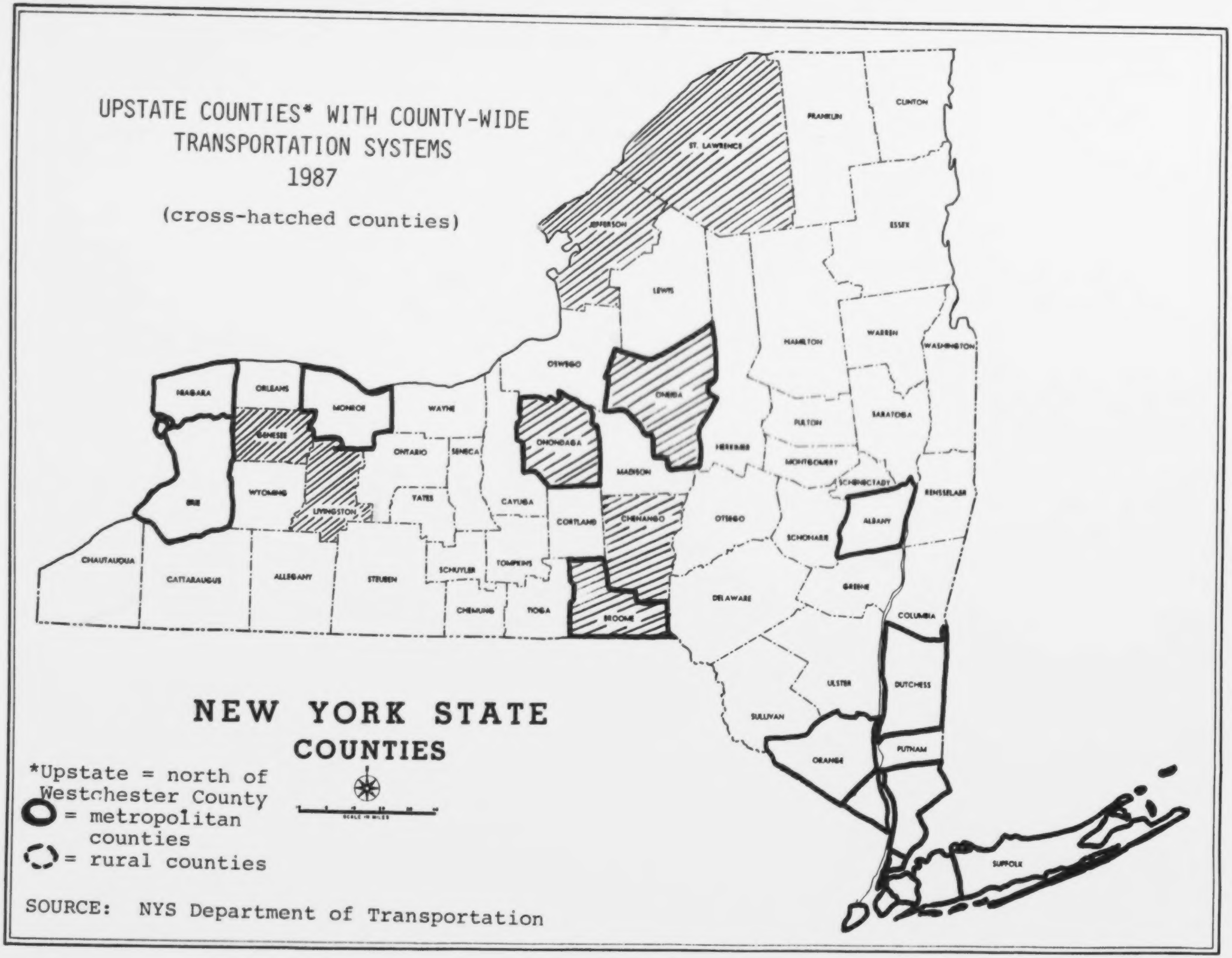
   The survival rate in rural areas for victims of auto accidents, fires and disasters is believed to be diminished in part because emergency medical vehicles must travel further distances under more dangerous conditions. Furthermore, emergency medical services in rural areas are often fragmented, and squads are facing increasing financial and staffing difficulties.

2. Transportation for Access to Health Services

   To receive health services many people in rural New York must travel long distances. Although most rural roads are adequate, a person in need of medical attention may be unable to undergo the stress of long auto trips. In the absence of available public transportation services or accessible health facilities, the individual often simply "waits until he/she is no longer sick."

Attempts are being made nationwide and in New York State to combat some of the difficulties associated with the delivery of rural emergency, and other transportation services. The Governor and the Legislature of New York have recognized the problems with public transportation in rural areas of the state and those associated with the delivery of health services. Consequently, the Rural Public Transportation Coordination Assistance Program was introduced by the Commission on Rural Resources and signed into law by the Governor July 24, 1986. This legislation provides a comprehensive state policy for the coordinated development and operation of public transportation services in the state's rural counties, and provides funding and technical assistance to rural counties planning to establish coordinated systems of public transportation.

The map on the following page shows those upstate counties that have countywide transportation systems.



UPSTATE COUNTIES* WITH COUNTY-WIDE TRANSPORTATION SYSTEMS
1987
(cross-hatched counties)

NEW YORK STATE
COUNTIES

*Upstate = north of Westchester County
⬭ = metropolitan counties
⬯ = rural counties

SOURCE: NYS Department of Transportation

FRANKLIN
CLINTON
ST. LAWRENCE
JEFFERSON
ESSEX
LEWIS
HAMILTON
WARREN
WASHINGTON
OSWEGO
ONEIDA
NIAGARA
ORLEANS
MONROE
WAYNE
GENESEE
ONTARIO
SENECA
ONONDAGA
FULTON
SARATOGA
HERKIMER
MONTGOMERY
MADISON
SCHENECTADY
ERIE
WYOMING
LIVINGSTON
YATES
CAYUGA
CORTLAND
CHENANGO
OTSEGO
ALBANY
RENSSELAER
SCHOHARIE
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN
SCHUYLER
TOMPKINS
GREENE
DELAWARE
CHEMUNG
TIOGA
BROOME
COLUMBIA
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
SUFFOLK
SCALE IN MILES

Case Management

A linking service which is vital to ensuring a client's awareness, accessibility, and confidence with the health system is assistance from persons who have knowledge of the system and are able to assist in coordinating his/her involvement. Because case management services are not readily accessible in rural areas, oftentimes people are uninformed and are therefore less likely to take advantage of the opportunities that are available. Case managers provide the link which connects a client with the appropriate health and related support services.

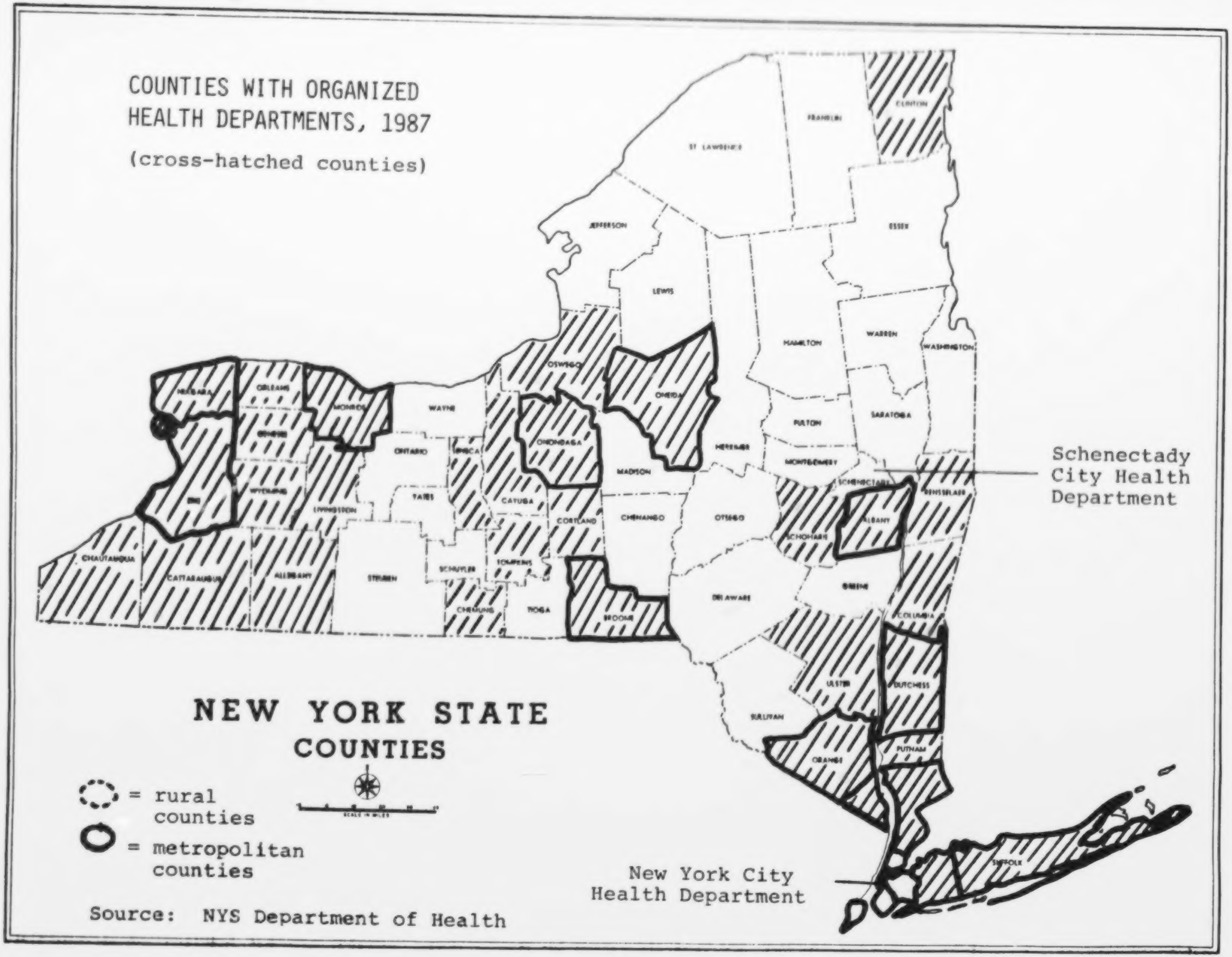
Many rural counties and areas have recognized the need for a case management system for health and human services, and have established regional case management offices and "hotlines." An expansion of these efforts would be greatly beneficial to rural citizens and the providers who serve them.

Public Education and Health Information Resources

Educational opportunities for both the client and the provider in a rural health services system are essential for the prevention and treatment of illness and promotion of a healthful living environment. Health information efforts are generally viewed as being insufficient in reaching rural citizens.

Because the health status of the public is affected greatly by lifestyle and genetic factors, the first reponsibility is to educate rural residents about such matters. People in rural areas are predominantly less healthy than their urban neighbors as they exhibit higher rates of chronic drinking, sedentary lifestyles, obesity, and accidents. However, people in rural communities may not even be aware of, and/or do not have access to, the services which would address these needs. Consequently, health education programs in rural communities are vital to the enhancement of the health status of rural citizens and communities.

There are a number of public and private entities which provide health information to the public. The local pharmacist, schools, and other community organizations often provide health information. County departments of health, mental health, and social services, as well as area offices for the aging and community action agencies, serve as major sources of health information in rural communities. In the forty-four rural counties of the state, almost all contain these entities, with the exception of health departments: only 18 of the 44 rural counties have organized county health departments. The map following this section shows the counties in the state that have organized health departments.



COUNTIES WITH ORGANIZED HEALTH DEPARTMENTS, 1987

(cross-hatched counties)

NEW YORK STATE
COUNTIES
ST LAWRENCE
FRANKLIN
CLINTON
ESSEX
JEFFERSON
LEWIS
HAMILTON
WARREN
WASHINGTON
OSWEGO
ONEIDA
NIAGARA
ORLEANS
MONROE
WAYNE
GENESEE
ONTARIO
SENECA
ONONDAGA
HERKIMER
FULTON
SARATOGA
MONTGOMERY
SCHENECTADY
RENSSELAER
MADISON
ERIE
WYOMING
LIVINGSTON
YATES
CAYUGA
CORTLAND
CHENANGO
OTSEGO
SCHOHARIE
ALBANY
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN
SCHUYLER
TOMPKINS
CHEMUNG
TIOGA
BROOME
DELAWARE
GREENE
COLUMBIA
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
SUFFOLK
SCALE IN MILES

◌ = rural counties

◯ = metropolitan counties

Schenectady City Health Department

New York City Health Department

Source: NYS Department of Health

Presently, rural residents face a double dilemma. Not only are they less healthy than their metropolitan neighbors, but they have less access to health service professionals. One of the main problems is the recruitment and retention of health care professionals. A major obstacle is the limited educational opportunities and informational resources for such professionals in rural areas. Until now, resources for medical and allied health training have been concentrated in large metropolitan medical centers. An emphasis on expanding and improving the volume and quality of teaching in rural settings would help to alleviate this situation. Another solution to this problem, being used in other states, is regional cooperation among hospitals with teaching centers. These hospitals promote outreach programs involving circuit-riding specialists who conduct one-day clinics. Another technique in continuing education is utilizing technological resources such as video cassettes, telecommunications, and speakerphones. Telecommunications and speakerphones are especially ideal as they offer two-way communication.

DEVELOPING A RURAL HEALTH SYSTEM FOR NEW YORK STATE

- Definitions of "Rural" and "Rural Hospital"
  - NYS Health Department Definitions
  - Federal Definitions
  - Commission Definitions
- Planning and Organizational Development
  - Health Planning Tools and Mechanisms
- Current and Future Financing
- Reimbursement
- Alternate Level of Care (ALC) and Swing Beds
- Capital Financing Issues
- Federal and State Agencies and Interest Groups
- Summary of Programs Administered by the State Health Department

DEVELOPING A RURAL HEALTH SYSTEM FOR NEW YORK STATE

System development as discussed here refers to those mechanisms, tools, policies, and strategies that implement or activate the rural health system framework and its components: in effect the "gas" or energy that will make the system run properly, be maintained and updated as required. Key ingredients in this regard are financing and reimbursement; education, training, recruitment and retention of personnel; monitoring, review and reporting; the application of proper criteria, rules, definitions, regulations, and standards; leadership, representation and organizational development; information, research and program development; and communication, cooperation and coordination. Some of these strategies are discussed in the following section.

DEFINITIONS OF "RURAL" AND "RURAL HOSPITAL"

A serious problem in researching and developing policy for rural health care is the inadequacy and inconsistency of definitions of the terms "rural" and "rural provider," as well as the inflexibility with which they are used. Currently, the federal and state governments have vastly different criteria for determining whether or not a particular area in the state is rural. Similarly, regional planners and individual providers each have their own conceptions of "rural." Concern over this discrepancy arises because the definitions are used as a basis for implementation of policy. Problems often arise when a particular definition is applied rigidly for all policies regardless of the problem or need being addressed and its perhaps unique context. Frequently, the definition takes on a policy complexion of its own.

Being defined as rural, by one or more of the various standards, can have serious consequences for a small hospital or other health care facility. For example, rural hospitals, as defined by the state government, are required to have a 65% bed utilization rate, in contrast to the 80% rate expected of other hospitals. In addition, hospitals and providers categorized as rural by the federal government's standards are reimbursed for their services at lower rates than other providers.

The Commission recognizes a need for flexibility in the use of definitions, to allow for diversity in program objectives and the problems to be addressed, as well as an area's capacity to respond to those problems. For example, when considering planning for health care centers and hospitals, a regional or county-based definition is most functional. However, primary care services are better reviewed at a more local level, such as the primary care analysis areas used by the State Health Department. Similarly, planning for emergency medical services requires more attention to the geographical layout of an area.

I. New York State Health Department Definition of a Rural Hospital

The definition of a rural hospital used by the State Health Department was originally devised in the early 1980s by the Rural Hospital Advisory Committee as a method of setting criteria for the allocation of funding for a new program of medical library services. Since that time, its use has expanded. It is currently the method of determining reimbursement eligibility for many state health programs which address much different needs and conditions than the original intent.

There are four major elements in this definition of a rural hospital, with the focus on the size of the facility and the population density of the area in which it is located. Also, there are six exceptions which would exclude facilities under certain conditions. Each of the four elements is weighted and the total score must be six or higher for the hospital to qualify as rural. The current point system is as follows:

Number of Acute Beds in Hospital

75 beds or under	3 points
76 to 100 beds	2 points

Population Density of County Where Located

Under 100 persons per square mile	3 points
Under 150 persons per square mile	2 points

Size of Hospital Budget

Under $6,500,000	2 points
Under $7,500,000	1 point

Number of Hospital Inpatient Admissions

Under 4,000	2 points
Under 4,500	1 point

All hospitals, after review under these criteria, which achieve a score of six or higher are determined to be rural, with the following exceptions:

1. Facilities in the following cities or counties:

   5 boroughs of NY City
   Nassau County
   Suffolk County
   Albany County
   Westchester County
   Orange County
   Schenectady County
   Rensselaer County
   Onondaga County
   Monroe County
   Erie County
   Oneida County

2. Facilities wherein OHSM is in a hearing concerning revocation of the operating certificate for structural or operational deficiencies.

3. Facilities wherein OHSM has issued a finding (subject to hearing) that the continued existence of the facility is not consistent with the public need.

4. Facilities wherein the HSA and/or SHRPC and/or OHSM have adopted a plan which calls for the termination or conversion of the facility.

5. Specialty hospitals.
6. Facilities wherein there is another existing acute care unit within five miles.

There are currently 50 hospitals in New York State meeting the criteria of "rural" by this definition.

II. New York State Health Department Definition of a Rural Area

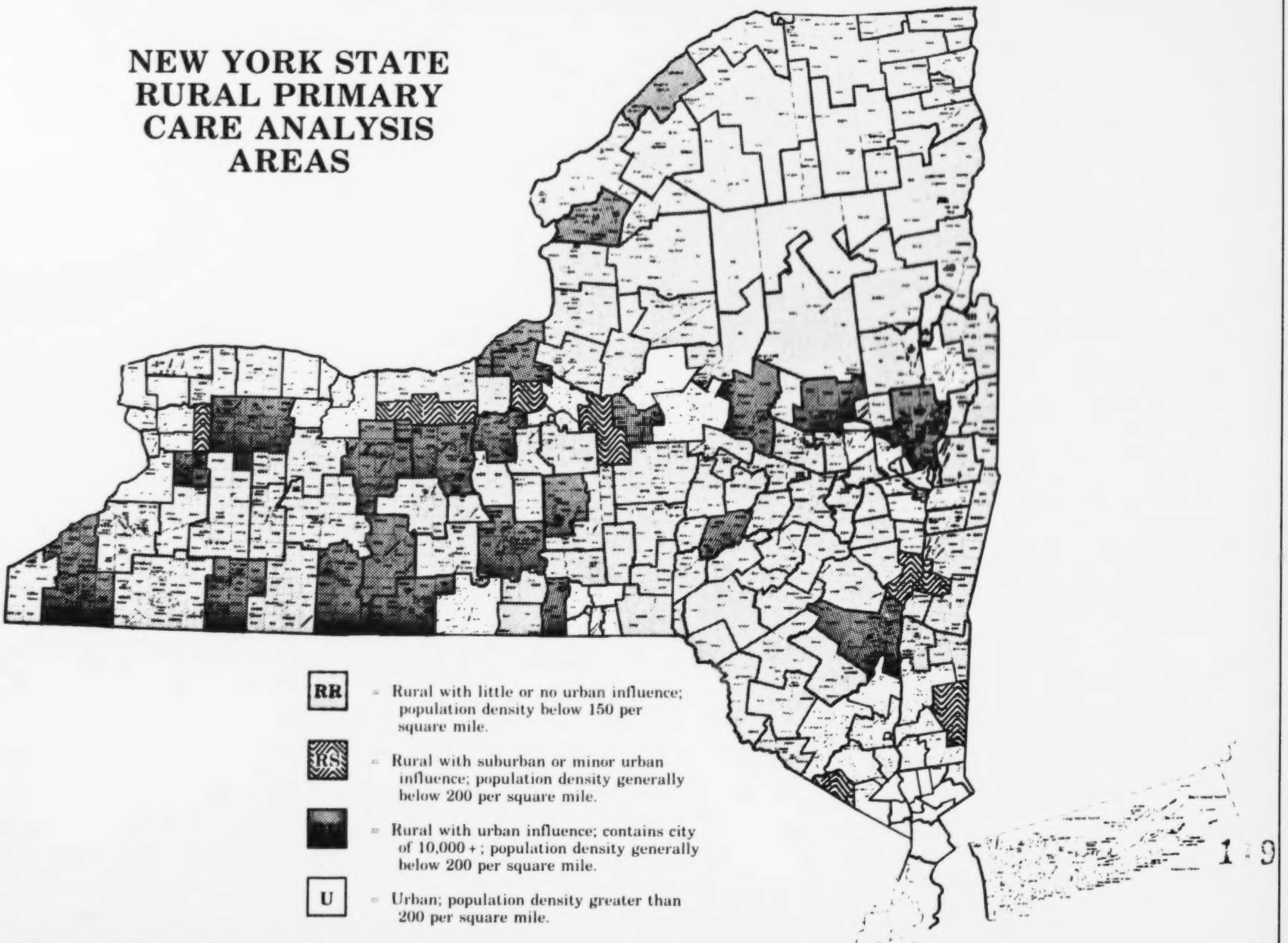
The New York State Department of Health uses Primary Care Analysis Areas (PCAAs) as its primary unit of analysis. Primary Care Analysis Areas can be used to compare health and socioeconomic characteristics of geographic areas smaller than counties, and thus are often a more accurate designation for health policy purposes. PCAA lines are drawn to include towns, census tracts, and minor civil divisions. The guidelines used to identify PCAAs were developed by the New York Statewide Health Coordinating Council.

In classifying the areas, several characteristics are considered. Criteria for the classification include minimum population base, population characteristics, typography, transportation networks and patterns, a maximum thirty minute travel limit, and existing nature of provider utilization and marketing areas.

The State Health Department, through its Task Force on Rural Health Strategies, has recently designated all of the PCAAs as rural or urban, using population density as its major variable. Population density of 3000 to 6000 people per square mile is considered high, and the mid-range population density is 200-300 people per square mile. PCAAs with high to mid-range population densities (greater than 200 people per square mile) are classified as urban, and rural PCAAs have a population density of less than 200 people per square mile.

The PCAAs are further classified using the size of the largest city, according to the following chart:

NEW YORK STATE RURAL PRIMARY CARE ANALYSIS AREAS



RR = Rural with little or no urban influence; population density below 150 per square mile.

RS = Rural with suburban or minor urban influence; population density generally below 200 per square mile.

RU = Rural with urban influence; contains city of 10,000+; population density generally below 200 per square mile.

U = Urban; population density greater than 200 per square mile.

Source: NYS Department of Health, 1987.

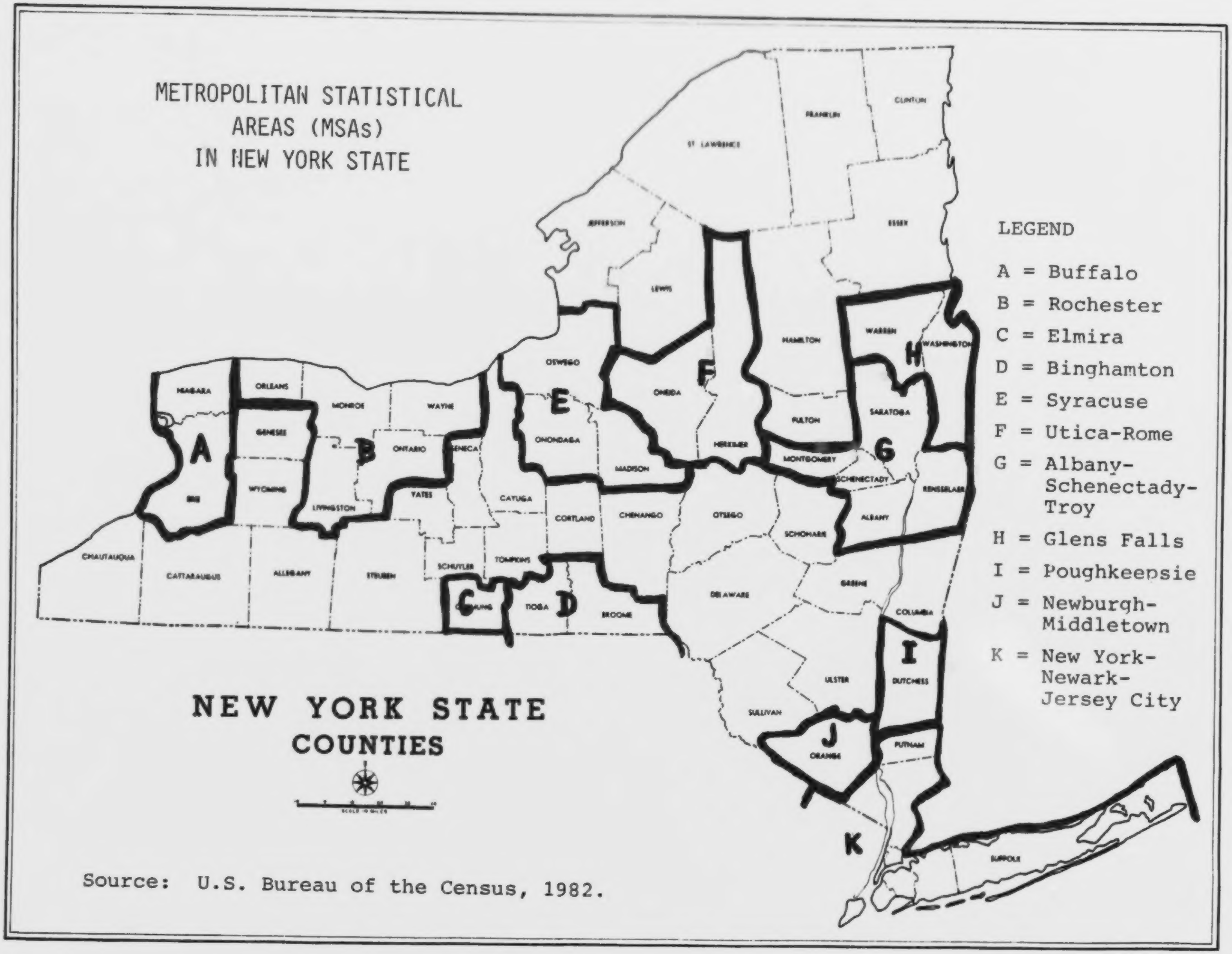
Classification		Number of PCAAs
Group 1:	**(U) Urban**	
	Population density greater than 200 per square mile	552
Group 2:	**(RR) Rural with little or no urban influence**	
	Population density less than 150 per square mile, with no city of more than 10,000	105
Group 3:	**(RU/RS) Rural with urban/suburban influence**	
	(RU) is rural with population density of less than or equal to 200 per square mile, containing a city of 10,000+	25
	(RS) is rural with population density less than or equal to 200 per square mile, with no city of more than 10,000. May include a city of less than 10,000; a densely populated town; a large town of 10,000+; or be adjacent to a more urban area	8

According to these designations, most PCAAs fall into the urban group, with New York City accounting for more than 60% of the urban PCAAs, and Nassau/Suffolk accounting for another 20%. The 138 rural PCAAs occupy the majority of the land area of upstate New York. A map of PCAAs is featured on the previous page.

III. Federal Definition of a Rural Hospital

1. Rural Hospital -- any hospital not located in a Metropolitan Statistical Area (MSA), which is defined as an area of one or more central counties containing one main population concentration (i.e., an urbanized area with at least 50,000 inhabitants). The MSA may also include outlying, largely rural, counties which have close economic and social relationships with the central counties (e.g., meeting specific standards regarding commuting patterns, population density, urban population, and population growth). Areas outside MSAs are frequently called "non-metropolitan," as opposed to "rural." (See map of Federal MSAs in New York State.)

There are currently 53 hospitals in New York State that are located outside of these federally-designated MSAs, and are thus classified as rural.


NEW YORK STATE
COUNTIES
A
B
C
D
E
F
G
H
I
J
K
NIAGARA
ORLEANS
MONROE
WAYNE
ERIE
GENESEE
WYOMING
LIVINGSTON
ONTARIO
SENECA
YATES
CAYUGA
OSWEGO
ONONDAGA
MADISON
ONEIDA
HERKIMER
JEFFERSON
LEWIS
ST LAWRENCE
FRANKLIN
CLINTON
ESSEX
HAMILTON
WARREN
WASHINGTON
FULTON
SARATOGA
MONTGOMERY
SCHENECTADY
RENSSELAER
ALBANY
SCHOHARIE
OTSEGO
CHENANGO
CORTLAND
TOMPKINS
SCHUYLER
CHEMUNG
TIOGA
BROOME
DELAWARE
GREENE
COLUMBIA
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
SUFFOLK
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN

METROPOLITAN STATISTICAL
AREAS (MSAs)
IN NEW YORK STATE

LEGEND

A = Buffalo
B = Rochester
C = Elmira
D = Binghamton
E = Syracuse
F = Utica-Rome
G = Albany-Schenectady-Troy
H = Glens Falls
I = Poughkeepsie
J = Newburgh-Middletown
K = New York-Newark-Jersey City

Source: U.S. Bureau of the Census, 1982.

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Other federal definitions used for reimbursement purposes in regard to providers serving rural areas are:

2. Sole Community Hospital -- any hospital which, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available to individuals. The specific criteria for designation as a sole community provider are:

i. The hospital is located more than fifty miles from other like hospitals, or

ii. The hospital is located between 25 and 50 miles from other like hospitals and either:

   a. No more than 25% of the residents in the hospital's service area are admitted to other like hospitals for care, or

   b. Because of local topography, weather, etc., the other hospitals are generally not accessible for more than one month in a twelve month period; or

   c. The hospital is located between 15 and 25 miles of other like hospitals and because of local topography, weather, etc., the other hospitals are generally not accessible for more than a month in a twelve month period.

Sole Community Hospital (SCH) status is granted for purposes of reimbursement under federal prospective payment systems, allowing them payment adjustments and exemptions from hospital cost limits. Specifically, an SCH is reimbursed according to the method of establishing rates for the first year of the transition period. In addition, an SCH may receive additional payments if the facility experienced a decrease of more than 5% of its inpatient cases due to circumstances beyond its control.

There are four hospitals in New York State that have been designated Sole Community Providers: Champlain Valley Physicians Hospital (Clinton County), Clifton-Fine Hospital (St. Lawrence Co.), Community General Hospital -- Harris Division (Sullivan Co.), and Moses-Ludington Hospital (Essex Co.).

3. Rural Referral Center -- for designation as a rural referral center a hospital must meet two mandatory criteria (case mix and number of discharges), and at least one of three optional criteria (specialty composition of medical staff, source of

inpatients, or volume of referrals) in addition to being located in a rural area (i.e., outside an MSA).

Rural Referral Centers are designated as such in order that they can qualify for exceptions and adjustments to federal Prospective Payment System amounts.

There are six hospitals in NYS that are considered Rural Referral Centers. They are: A.O. Fox Memorial (Otsego County), Auburn Memorial (Cayuga County), Benedictine Hospital (Ulster Co.), Columbia Memorial (Columbia Co.), M.I. Bassett Hospital (Otsego County), and Olean General Hospital (Cattaraugus County).

III. Commission on Rural Resources' Definition of Rural

In considering the provision of health services, the Commission defines the term rural flexibly, depending on the use to which the definition will be put.

Usually a town is considered rural when the population density is less than 150 persons per square mile.* Counties of under 200,000 population are also considered rural. There are some 700 towns out of 932 that are thus classified as rural, and 44 counties of the 57 outside of New York City that are rural.

In Paul R. Eberts' Socioeconomic Trends in Rural New York State: Toward the 21st Century, a scheme of six types of counties are identified. County types are labeled as follows:

Type 1. Downstate metropolitan counties
Type 2. Upstate metropolitan counties
Type 3. Rural counties under extensive urban influence
Type 4. Rural counties under considerable urban influence
Type 5. Rural counties under moderate urban influence
Type 6. Rural counties under limited urban influence

The counties were initially classified by population. A breakpoint of 200,000 in county population was used for separating metropolitan from non-metropolitan (or rural) counties. By this formulation, eighteen New York counties are metropolitan and forty-four are rural. The eighteen metropolitan counties were designated as type 1 and type 2 by separating the metropolitan counties by the percentage of rural (or non-urban) population -- that is, the percentage of people who do not live in places of 2,500 or more people. When the eighteen metropolitan counties (those with more than 200,000 people) are divided into those with more than 10 percent nonurban and those with less than 10 percent nonurban, then nine counties fall into each grouping. Moreover, the nine which have less than 10 percent of their population living in rural places are all in the New York City area, while the remaining are upstate.

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*See Population Density Map for New York State Towns, located on the inside back cover of this guide.

The 44 rural counties have degrees of "ruralness" (or "urbanness") which were subdivided using two criteria, which separate the counties according to their similarities and differences. These two criteria are the percentage of people in the counties who commute outside for employment, and the size of the largest place in the counties. The latter is an important criterion because the size of the largest place in a county often defines the general social, political, and economic character of a county in a "more urban" or "more rural" way. The following chart demonstrates the categories into which the 44 rural counties were divided.

		Size of Largest Place in County (10,000 or More Persons)		
		Higher than 10,000	Lower than 10,000	
Percentage of Work Force Which Commutes Outside County of Residence for Employment	Higher (20% or more)	3. Extensive Urban Influence Cayuga Fulton Genesee Madison Montgomery Ontario Oswego Rensselaer Saratoga Schenectady Wayne (N = 11)	5. Moderate Urban Influence Columbia Greene Hamilton Herkimer Livingston Orleans Putnam Schoharie Schuyler Seneca Tioga Washington Wyoming Yates (N = 14)	(N = 25)
	Lower (19.9% or less)	4. Considerable Urban Influence Cattaraugus Chautauqua Chemung Clinton Cortland Jefferson Otsego St. Lawrence Steuben Tompkins Ulster Warren (N = 12)	6. Limited Urban Influence Allegany Chenango Delaware Essex Franklin Lewis Sullivan (N = 7)	(N = 19)
		(N = 23)	(N = 21)	Total N = 44

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*Urban influence is defined here as a function of size of largest municipality in a county and the percentage of the county's work force which commutes outside the county for employment.

The 1980 Census showed that 3,088,546 people live in rural counties of the state, as defined in the Eberts study, accounting for 17.6% of the state's total population.

According to this scheme, there are currently 90 hospitals located in those 44 rural counties.

HOSPITALS CONSIDERED "RURAL"
(1987)

HOSPITAL NAME	COUNTY	COMMISSION DEFINITION	STATE DEF	FEDERAL DEFINITIONS SOLE COMMUNITY PROVIDER	FEDERAL DEFINITIONS RURAL HOSPITAL	FEDERAL DEFINITIONS RURAL REFFERAL CENTER
A. Barton Hepburn Hospital	St. Lawrence	X	X		X	
A. Lindsay & Olive B. O'Connor	Delaware	X	X		X	
A.O. Fox Memorial	Otsego	X			X	X
Adirondack Regional	Saratoga	X	X			
Albert Lindley Lee Memorial	Oswego	X	X			
Alice Hyde Memorial	Franklin	X	X		X	
Amsterdam Memorial	Montgomery	X				
Arnold Gregory Memorial	Orleans	X	X			
Arnot-Ogden Memorial	Chemung	X				
Auburn Memorial	Cayuga	X			X	X
Bassett Hospital	Otsego	X			X	X
Bellevue Maternity	Schenectady	X				
Benedictine Hospital	Ulster	X			X	X
Brooks Memorial	Chautauqua	X			X	
Canton-Potsdam Hospital	St. Lawrence	X	X		X	
Carthage Area Hospital	Jefferson	X	X		X	
Champlain Valley Physicians	Clinton	X		X	X	
Chenango Memorial	Chenango	X	X		X	
Clifton Springs	Ontario	X				
Clifton-Fine Hospital	St. Lawrence	X	X	X	X	
Columbia Memorial	Columbia	X	X		X	X
Community (Cobleskill)	Schoharie	X	X		X	
Community (Stamford)	Delaware	X	X		X	
Community General - G. Herman Div.	Sullivan	X	X		X	
Community General - Harris Div.	Sullivan	X		X	X	
Community Memorial (Hamilton)	Madison	X	X			
Corning Hospital	Steuben	X			X	
Cortland Memorial	Cortland	X			X	
Cuba Memorial	Allegany	X	X			
Delaware Valley	Delaware	X	X		X	
E.J. Noble (Alex. Bay)	Jefferson	X	X		X	
E.J. Noble (Gouverneur)	St. Lawrence	X	X		X	
Elizabethtown Community	Essex	X	X		X	
Ellenville Community	Ulster	X	X		X	

				FEDERAL DEFINITIONS		
HOSPITAL NAME	COUNTY	COMMISSION DEFINITION	STATE DEF	SOLE COMMUNITY PROVIDER	RURAL HOSPITAL	RURAL REFFERAL CENTER
Ellis Hospital	Schenectady	X				
Emma Laing Stevens	Washington	X	X			
F.F. Thompson	Ontario	X				
General Hospital of Saranac Lake	Franklin	X	X		X	
Genesee Memorial	Genesee	X			X	
Geneva General	Ontario	X				
Glens Falls Hospital	Warren	X				
House of the Good Samaritan	Jefferson	X			X	
Inter-Community (Newfane)	Niagara		X			
Ira Davenport Memorial	Steuben	X	X		X	
Jamestown General	Chautauqua	X			X	
Johnstown Hospital	Fulton	X	X		X	
Jones Memorial	Allegany	X	X		X	
Julia L. Butterfield Memorial	Putnam	X	X			
Kingston Hospital	Ulster	X			X	
Lake Shore Hospital	Chautauqua	X	X		X	
Leonard Hospital	Rensselaer	X				
Lewis County General	Lewis	X	X		X	
Little Falls	Herkimer	X	X			
Margaretville Memorial	Delaware	X	X		X	
Mary McClellan	Washington	X	X			
Massena Memorial	St. Lawrence	X	X		X	
Medina Memorial	Orleans	X	X			
Memorial Hospital (Catskill)	Greene	X	X			
Mercy Hospital (Watertown)	Jefferson	X			X	
Mohawk Valley General	Herkimer	X	X			
Moses-Ludington	Essex	X	X	X		
Myers Community	Wayne	X	X			
Nathan Littauer	Fulton	X			X	
Newark-Wayne	Wayne	X				
Nicholas H. Noyes Memorial	Livingston	X	X			
Northern Dutchess	Dutchess		X			

				FEDERAL DEFINITIONS		
HOSPITAL NAME	COUNTY	COMMISSION DEFINITION	STATE DEF	SOLE COMMUNITY PROVIDER	RURAL HOSPITAL	RURAL REFFERAL CENTER
Olean General	Cattaraugus	X			X	X
Oneida City Hospital	Madison	X	X			
Oswego Hospital	Oswego	X				
Placid Memorial	Essex	X	X		X	
Putnam Hospital Center	Putnam	X				
Salamanca District Hospital	Cattaraugus	X	X		X	
Samaritan Hospital	Rensselaer	X				
Saratoga Hospital	Saratoga	X				
Schuyler Hospital	Schuyler	X	X		X	
Seneca Falls	Seneca	X			X	
Soldiers & Sailors Memorial	Yates	X	X		X	
St. Clare's	Schenectady	X				
St. Francis	Cattaraugus	X			X	
St. James Mercy	Steuben	X			X	
St. Jerome	Genesee	X			X	
St. Joseph's	Chemung	X				
St. Mary's (Amsterdam)	Montgomery	X				
St. Mary's (Troy)	Rensselaer	X				
Sunnyview Hospital	Schenectady	X				
The Hospital (Sidney)	Delaware	X	X		X	
Tioga General	Tioga	X	X			
Tompkins Community	Tompkins	X			X	
Tri-County Memorial	Cattaraugus	X	X		X	
Waterloo Memorial (Taylor Brown)	Seneca	X			X	
Westfield Memorial	Chautauqua	X	X		X	
Woman's Christian Association	Chautauqua	X			X	
Wyoming Co. Community	Wyoming	X	X			
	TOTALS	90	50	4	53	4

EBERTS URBAN/RURAL TYPOLOGY BY NYS COUNTY

(Based on 1980 Census)

TYPE	1	2	3	4	5	6
	DOWNSTATE METROPOLITAN	UPSTATE METROPOLITAN	RURAL WITH EXT. URBAN	RURAL WITH CONSIDERABLE URBAN	RURAL WITH MODERATE URBAN	RURAL WITH LIMITED URBAN
TOTAL #	9	9	11	12	14	7
	(1) Bronx*	(1) Albany	(2) Cayuga	(2) Cattaragus	(2) Columbia	(2) Allegany
	(1) Kings*	(1) Broome	(2) Fulton	(2) Chautauqua	(2) Greene	(2) Chenango
	(1) Nassau	(1) Dutchess	(2) Genesee	(1) Chemung	(2) Hamilton	(2) Delaware
	(1) New York*	(1) Erie	(3) Madison	(2) Clinton	(3) Herkimer	(2) Essex
	(1) Queens*	(1) Monroe	(3) Montgomery	(2) Cortland	(3) Livingston	(2) Franklin
	(1) Richmond*	(1) Niagara	(3) Ontario	(2) Jefferson	(3) Orleans	(2) Lewis
	(1) Rockland	(1) Oneida	(3) Oswego	(2) Otsego	(1) Putnam	(2) Sullivan
	(1) Suffolk	(1) Onondaga	(1) Rensselaer	(2) St. Lawr.	(2) Schoharie	
	(1) Westchester	(1) Orange	(1) Saratoga	(2) Steuben	(2) Schuyler	
			(1) Schenectady	(4) Tompkins	(2) Seneca	
			(3) Wayne	(2) Ulster	(3) Tioga	
				(3) Warren	(3) Washington	
					(2) Wyoming	
					(2) Yates	

Key	Total
* NY City	
(1) Both MSA and over 150 persons/sq. mile	23
(2) Neither MSA nor 150 persons/sq. mile	27
(3) MSA, but under 150 persons/sq. mile	11
(4) Not MSA, but over 150 persons/sq. mile	1
	62

MSA = Metropolitan Statistical Area

Source: Socioeconomic Trends in Rural New York State: Toward the 21st Century. Paul R. Eberts. September 1984.

ALTERNATIVE URBAN/RURAL DEFINITIONS BY COUNTY

	Statistical Area		Eberts Typology		Population Density	
	URBAN MSA	RURAL NON-MSA	URBAN OVER 200,000	RURAL UNDER 200,000	URBAN OVER 150/sq. mile	RURAL UNDER 150/sq. mile
TOTAL #	34	28	18	44	24	38
	Albany	Allegany	Albany	Allegany	Albany	Allegany
	Broome	Cattaragus	*Bronx	Cattaragus	*Bronx	Cattaragus
	*Bronx	Cayuga	Broome	Cayuga	Broome	Cayuga
	Chemung	Chautauqua	Dutchess	Chautauqua	Chemung	Chautauqua
	Dutchess	Chenango	Erie	Chemung	Dutchess	Chenango
	Erie	Clinton	*Kings	Chenango	Erie	Clinton
	*Queens	Columbia	Monroe	Clinton	*Kings	Columbia
	Herkimer	Cortland	Nassau	Columbia	Monroe	Cortland
	*Kings	Delaware	*New York	Cortland	Nassau	Delaware
	Livingston	Essex	Niagara	Delaware	*New York	Essex
	Madison	Franklin	Oneida	Essex	Niagara	Franklin
	Monroe	Fulton	Onondaga	Franklin	Oneida	Fulton
	Montgomery	Genessee	Orange	Fulton	Onondaga	Genesee
	Nassau	Hamilton	*Queens	Genesee	Orange	Greene
	*New York	Jefferson	*Richmond	Greene	Putnam	Hamilton
	Niagara	Lewis	Rockland	Hamilton	*Richmond	Herkimer
	Oneida	Otsego	Suffolk	Herkimer	Rockland	Jefferson
	Onondaga	Saint Lawrence	Westchester	Jefferson	Saratoga	Lewis
	Orange	Schoharie		Lewis	Schenectady	Livingston
	Orleans	Schuyler		Livingston	Suffolk	Madison
	Oswego	Seneca		Madison	Tompkins	Montgomery
	Putnam	Steuben		Montgomery	Westchester	Ontario
	Rensselaer	Sullivan		Ontario	*Queens	Orleans
	*Richmond	Tompkins		Orleans	Rensselaer	Oswego
	Rockland	Ulster		Oswego		Otsego
	Saratoga	Wyoming		Otsego		SaintLawrence
	Schenectady	Yates		Putnam		Schoharie
	Suffolk	Greene		Rensselaer		Schuyler
	Tioga			SaintLawrence		Seneca
	Warren			Saratoga		Steuben
	Washington			Schenectady		Sullivan
	Wayne			Schoharie		Tioga
	Westchester			Schuyler		Ulster
	Ontario			Seneca		Warren
				Steuben		Washington
				Sullivan		Wayne
				Tioga		Wyoming
				Tompkins		Yates
				Ulster		
				Warren		
				Washington		
				Wayne		
				Wyoming		
				Yates		

* NY City
MSA = Metropolitan Statistical Area

Planning and Organizational Development

Traditionally, most health services have been planned and provided on an individual basis. Case management is a key component in order to follow clients' progression in the system. In effect, there really has not been a comprehensive "system" of rural health services, per se, but rather individual providers functioning as loosely knit members of independent subsystems.

In terms of planning and organizing for the future, however, trends strongly suggest the need for more formal inter-organizational and interinstitutional arrangements in the delivery of health services. These trends are especially significant in rural areas, where sparse populations and scarce resources do not allow for unbridled competition among a great number of providers. Moreover, such combining of resources is generally accepted as the most efficient and effective method of delivering services.

Interorganizational arrangements focus on cooperative planning and development of both vertical and horizontal linkages of services and support systems. A goal is coordinated provision of health services. This may involved cooperation and sharing of resources (e.g., buildings, equipment) and health personnel.

Health Planning Tools and Mechanisms*

- State Health Plan and State Health Systems Plans
- Medical Facilities Plan
- Regional Health Systems Agencies
- Regional Plans for Primary Care and Preventive Health Services
- Need Methodologies
- Certificate of Need Process
- Rural Health Network Demonstration Grants
- Rural Health Care Services Diversification Program

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*Used by the New York State Department of Health

Current and Future Financing

Another important aspect of a rural health system that must be considered is financing. Two main problems associated with financing must be addressed in order to have a network of adequate health services in rural areas. These are: (1) rural facilities and providers have historically been reimbursed at lower rates than their metropolitan counterparts, for the same services; and (2) the overall structure of financing mechanisms is geared toward the provision of individual, presumably unrelated services.

While the unequal reimbursement rates for rural providers is a major obstacle that may be overcome by improved data, the greatest difficulty in terms of networking is in designing financing mechanisms that encourage and allow for cooperation in planning and implementing services.

Currently, the regulation of the health care system is organized along program lines (e.g., Title 18 vs. Title 19; general hospitals vs. residential health facilities vs. home health agencies, etc.). Governmental agencies and bureaucracies, as well as service providers, are similarly organized and segregated. Each department in these organizations, and each type of health provider, is trained to focus on specific program areas. All too often, there is little attention to, or knowledge of, how one program area or one service affects another.

Studies have shown that rural hospitals have been disadvantaged financially by the Medicare DRG system when compared to urban hospitals. Congress recently made changes to partially alleviate the problem. However, careful consideration must be given to its effect on rural hospitals.

In addition, the State Legislature passed legislation in the 1987 sessions which would have established a case payment system for hospital inpatient reimbursement by non-Medicare payors beginning in 1988 and continuing through 1990. The bill was supported by numerous state organizations and associations, including: The Hospital Association of NYS, Hospital Trustees of NYS, Medical Society of NYS, NYS Public Health Association, NYS HMO Conference, NY Conference of Blue Cross/Blue Shield, and the Health Insurance Association of America.

In 1988, this system would be based on 100% hospital-specific costs (using 1985 as the base year); in 1989 and 1990, reimbursement would be a blend of hospital-specific costs and a pricing component (not to exceed 25% of the price). It would also provide for the continued availability of bad debt and charity care funds through the hospital reimbursement system.

This legislation was vetoed by the Governor on August 10, 1987. In his veto message to the Senate, the Governor expressed his willingness to continue working with the Legislature to develop an affordable hospital reimbursement system for the state, but he critized the structure of this bill, stating that it would result in an overwhelmingly expensive system, and an inability to properly control hospital costs. The Governor continued by stating, "Increased costs, unnecessarily delayed reform, and basic unfairness are the consequences of approving this bill. The consequences of disapproving it are, in my view, far more beneficial to the public."

The current hospital reimbursement system -- NYPHRM II -- is scheduled to end at the conclusion of 1987. Thus, the veto of this bill leaves New York State without a reimbursement system -- and leaves the development of a new inpatient reimbursement structure almost completely up to the regulatory process.

A service price system for home health reimbursement is being studied and designed by the Department of Health for initial phase-in in 1988. Under such a system, payment rates would be uniform for a specific service but would most likely be adjusted for rural-urban differences in costs and for regional differences in wage rates. Also being considered is requesting a waiver to apply this system to Medicare after applying it first to Medicaid. The effect on rural providers of these changes in reimbursement is unknown. Strict standards used in determining eligibility for Medicare reimbursement result in difficulties with home health care reimbursement.

Alternative providers also face difficulties in terms of the future of financing. Because of lack of recognition, especially regarding nurse practitioners, it is difficult for such providers to work on their own and bill separately. Also, outpatient care is not reimbursed to the same extent as hospital inpatient care. Only about 10 percent of hospital inpatient expenses are subject to direct payment by the patient in comparison to about 35 percent of outpatient services. In addition, there is a lack of development money, as well as financial sophistication, in small rural hospitals.

While health care services and individual providers are in many ways gradually headed toward integration, methods of consolidating and regulating financing to encourage integration are not adequate.

One such financing mechanism is the HMO or PPO. Other capitation financing mechanisms are currently being discussed by policymakers and third-party payors. Pilot projects such as the previously mentioned New York State Rural Health Networking Program, and the new Rural Health Care Services Diversification Program, may help identify required adjustments in rural financing mechanisms.

A chart on the following pages describes current reimbursement systems for various health care providers.

NEW YORK STATE

Current (1987) Reimbursement for Various Health Care Providers

		MEDICARE	MEDICAID	BLUE CROSS	OTHERS
1)	Hospitals - Inpatient	Case payment - 470 types of cases or DRGs (diagnosis related groups). Rates based 25% on the hospital's own historical costs and 75% on historical national costs.	NYPHRM II - average all-inclusive per day rate based on historical costs (1981), subject to disallowances for efficiency standards, trended forward. All rates and charges except for Medicare contain an add-on which are pooled and distributed back to hospitals on the basis of their bad debt/charity care need. Hospitals are also assessed a portion of their revenue for this purpose.		Hospital charges but capped at 13.6% above the Blue Cross rate.
	% of days (statewide average)	45%	18%	25%	12%
2)	Residential Health Care Facilities (skilled nursing and health related)	Reasonable costs less co-pay amounts.	RUGS - a per day rate is calculated based on 1983 costs trended. For direct patient care costs (45% of total costs) reimbursable costs are determined by using peer groups and a facility's case mix for 16 different patient categories (RUGS - Resource Utilization Groups). Indirect patient care costs are subject to peer group ceilings while all other costs are pass-throughs.	Reasonable costs or in some cases on special methodology.	Charges with no cap. Most private pay patients eventually spend down and go on Medicaid.
	% of days (statewide average)	4%	81%	2%	13%

Source: New York State Council on Health Care Financing. 1987

NEW YORK STATE

	MEDICARE	MEDICAID	BLUE CROSS	OTHERS
3) Hospitals - Outpatient				
a) Emergency Rooms	Reasonable cost less deductibles and co pays.	All-inclusive per visit rate based on 1984 costs trended and subject to a maximum amount of $72 plus capital costs.	Some BC plans pay an all-inclusive per visit rate but capped. Others pay charges capped at 150% of the hospital's inpatient rate.	Usually charges with no cap but sliding fee scale for private pay who are indigent.
% of visits (statewide average)	9%	21%	24%	46%
b) Clinics	Reasonable cost less deductibles and co pays.	All-inclusive per visit rate based on 1984 costs trended and subject to a maximum amount of $60 plus capital costs.	Limited coverage - usually payment is based on charges capped at 150% of the hospital's inpatient rate.	Usually charges with no cap but sliding fee scale for private pay who are indigent.
% of visits (statewide average)	15%	37%	3%	45%
c) Ambulatory Surgery	Reasonable cost less deductibles and co-payment. Some places are designated hospital affiliated ambulatory surgery centers and there are no co-pays or deductibles. Also physician payment - Medicare fee.	Rate based on budgeted costs (or actual costs if available) but capped at 150% of the hospital's inpatient rate plus capital costs. Also physician payment - Medicaid fee.	Same as Medicaid or charges capped at 150% of inpatient rate.	Usually charges with no cap.
% of visits	Not available	Not available	Not available	Not available

NEW YORK STATE

	MEDICARE	MEDICAID	BLUE CROSS	OTHERS
4) Diagnostic and Treatment Centers (Free standing Clinics)				
a) Primary multi-purpose & single speciality	80% of reasonable and customary charges - patient billed the remainder.	An all-inclusive per visit rate based on 1984 costs trended but limited to the result of the facility's group average costs plus 5% plus capital costs (groups are formed by segregating facilities according to region and comparable services).	Limited coverage - usually only special contractual arrangements with a particular freestanding clinic.	Limited coverage for commercial insurers. Private pays pay charges or a sliding fee scale.
% of visits (statewide average)	5%	40%	1%	54%
b) Ambulatory Surgery Centers - currently in the process of being certified.	Based on discrete prices for each of four groupings of surgical procedures.	Same concept as Medicare	Charges?	Charges with no cap.
% of visits	Not available	Not available	Not available	Not available
5) Certified home Health Agencies (CHHAs)	Cost-based limits based at 120% of nationally computed average per visit costs. Will be reduced in future years and are applied by visit disciplines - skilled nursing, physical therapy, speech parthology, occupational therapy, medical social services and home health aide services. Broken into labor & nonlabor costs with regional wage variations.	Lower of allowable costs held to ceiling or charges. Four separate peer groups established (freestanding voluntary and public agencies in upstate & downstate locations). Cost ceilings on skilled nursing and therapy visits, home health aide visits, and hourly aide ser-services. Hospital-based CHHAs held to 110% of cost ceilings for community-based CHHAs.	Usually signed participation contracts with individual CHHAs - pay a percentage of agency costs or charges	Charges with no cap. May be sliding fee scale for private pay indigent.
% of visits (statewide average)	55%	30%	5%	10%

NEW YORK STATE

		MEDICARE	MEDICAID	BLUE CROSS	OTHERS
6)	Nursing Home Without Walls (Long Term Home Health Care)	Same as CHHAs	Allowable costs for each service subject to cost guidelines. Separate peer groups for upstate, downstate.	-------	Charges
	% of patients (Primary payor)	Medicare pays a portion of the costs for some patients.	97%	---	3%
7)	Health Maintenance Organizations (HMOs)	Risk demonstration contracts- HMO paid 95% of the average area per capita costs for all Medicare enrollees. Otherwise, cost contracts arranged.	Negotiate capitated rates - cannot pay more than what services would otherwise cost. There is still a lack of adequate actuarial data on these recipients.	Pre-negotiated and fixed prepayment based on actuarial estimates for the type of population enrolled.	
	% of enrollees	Small #	Small #	----------------------majority------------------------	
8)	Physicians	Regional variations, Reasonable charge - 80% paid to physician, he can collect remaining 20% from patient. May accept patient on assignment - bills Medicare directly for 80%, patient for 20% or nonassignment where patient billed usual charge and patient collects from Medicare.	Single statewide fee schedule - fees usually much lower than physician actual charges.	Blue Shield fee schedule with regional variations	Fee schedules, charges for private pay.
	% of visits	Not available	Not available	Not available	Not available

NEW YORK STATE

9) **Alternative Providers**

a) Physician Assistants [1]

b) Nurse Practitioners [2]

c) Nurse Midwives [3]

Institutional Settings

Costs are included in total costs of facility and reimbursed the same as any other cost for that facility. Third party payor is usually not aware that the alternative provider has provided services.

Non-institutional Settings

Medicaid - nurse-midwives can bill separately. For the others, private practicing physicians submit claims in own name - physician assistant can be noted on the forms as providers, but nurse practitioner cannot because they are not recognized as separate providers.

Medicare - no recognition of medical services delegated to nurse practitioners or physician assistants. Only physicians can bill.

Commercial insurers - some have taken initiative in providing insurance benefits for the services of alternative providers, however, in most cases payment is made indirectly through bills submitted by physician. Exception - nurse-midwives - New York State law - commercial carriers are required to include nurse-midwives as covered providers in policies with maternity coverage.

Source: New York State Council on Health Care Financing

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[1] Physician assistants have been registered to practice in New York State under the supervision of a physician since 1972.

[2] Nurse practitioner is not an officially recognized title in New York State. During the last few years legislation has been proposed that would recognize the fuller training of nurse practitioners - (Current legislation is S.1314/A.1412).

[3] Nurse-midwives have been authorized to practice in New York City since 1959 and the rest of the state since 1972

ALTERNATE LEVEL OF CARE (ALC) AND SWING BEDS

Alternate Level of Care

Alternate level of care days are those days of care provided by a general hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that some lower level of care (rehabilitation, nursing home, or home health services) is medically necessary and being provided by the hospital.

In order to meet federal requirements the State, since 1983, has had regulations to pay for alternate level of care days at a rate lower than the hospital's inpatient rate unless certain utilization standards were met. For the years 1983-1985 a hospital would be paid this lower rate if the hospital was located in a HSA (Health Systems Agency) region which did not meet minimum medical/surgical occupancy standards based on 85 percent utilization for urban hospitals and 80 percent for rural hospitals, and the hospital itself did not meet such occupancy standards and did not apply for decertification of a sufficient number of beds for this level of occupancy to be attained.

In 1983 and 1984 these provisions did not result in penalties because occupancy rates in general remained fairly high. In 1985 several HSA regions were in danger of not meeting the requirements; however, enough beds were decertified so that most hospitals escaped the penalty.

Regulations for 1986 and 1987 originally required that a lower rate would be paid for ALC days unless both the region and the hospital met the utilization requirements. The utilization requirements were changed to 80 percent occupancy for urban hospitals, not counting ALC days, and 65 percent for rural hospitals, not counting ALC days. Under this regulation a hospital would be penalized, regardless of its own occupancy rate, if the region did not meet the occupancy test. New York State was successful in receiving federal statutory authority to revise the regulation so that an individual hospital which meets the minimum occupancy standards will not be penalized.

Hospitals were also allowed to decertify beds and not have these beds count in the calculation of 1986 minimum occupany standards. Because utilization continued to decline in 1986 many hospitals were forced to decertify beds to escape the penalty. Some 2700 beds were decertified up through the middle of February. There are still hospitals which will be penalized, but the data on the exact number are not available. Those which are penalized will be paid for ALC at the regional average Medicaid rate for residential health care facilities exclusive of capital cost, plus the hospital's capital costs. If a hospital establishes a discrete ALC patient care unit, costs will be reallocated to other service areas resulting in the hospital minimizing its losses.

The decertification of beds is causing additional problems. Since the occupancy standard is calculated without using ALC days, after a hospital decertifies beds to meet the standard and then the ALC beds are added to the total, the hospital may be using more beds than for which it is now certified. The solution for this has not yet been worked out. The Health Department has mentioned giving the hospitals 90 days to submit a plan on how they would reduce their census so they are not over their certified bed capacities. Hospitals are concerned that with the bed decertifications they will not have adequate beds to meet seasonal fluctuations in utilization or other needs for increased utilization.

On a statewide basis ALC days account for approximately 7 percent of total patient days. This, of course, varies by hospital. For many rural hositals, in particular, ALC days count for a much larger portion of total days (60% in some cases). This can be attributed to the large number of elderly living in rural areas as well as the lack of adequate back-up services in some areas.

The alternate level of care issue is seen as one of the most difficult problems facing health care providers. The Health Department often seems to take the position that hospitals are not doing enough to alleviate the problem. Hospitals, on the other hand, claim that they do not want the patients but the back-up services are not there, so there is no place to transfer them.

The RUGS (Resource Utilization Groups) reimbursement methodology for nursing homes is meant to partially deal with the ALC problem. There is evidence that nursing homes have taken more of the heavier care patients from hospitals; however, a different type of patient (needing more chronic care) is now left in the hospital. It is difficult to assess whether total ALC days have declined because of RUGS. The growth of home health care is also expected to reduce the problem.

The Senate and Assembly, in the past, have approved presumptive eligibility legislation which has been vetoed by the Governor. Under presumptive eligibility, in order to promote a faster transfer of patients from the hospital, patients under specified conditions can be presumed Medicaid eligible. Nursing homes and home health agencies are often reluctant to take patients without a guaranteed payment source.

As previously mentioned, alternate level of care provides a particualar problem for rural hospitals. There are a large number of elderly and the lack of back-up services. Although the State is encouraging the growth of home care, there are problems with home care in rural areas due to the sparse population, travel times, and lack of personnel. With some rural hospitals having ALC days count for over 50 percent of total days, the Health Department questions whether these hospitals are acting as nursing homes or acute care hospitals. This has, in part, led to their consideration of hospital closures and conversions.

Swing Beds

Another service delivery option chosen by rural hospitals nationwide is the use of "swing beds." A swing bed is a certified hospital bed which can be used alternatively for acute care or for skilled nursing (or even intermediate level) care, depending on the particular needs of the community at a given time. However, New York State has not adopted this concept.

The swing bed idea was first proposed and tested in the early 1970's, in response to the dilemma of an excess of certified acute care beds, and a scarcity of nursing home and home health services in rural communities. By "swinging" some of its beds, a hospital can provide a necessary link between acute and long term care.

Various swing bed demonstration projects have been evaluated in the past fifteen years, and have been found to be highly successful. Among the many benefits of the program are:

a.) providing a means of diversification, particularly for rural hospitals experiencing financial distress, by increasing occupancy rates, making more efficient use of hospital staff and resources, and contributing to the overall economic structure of the community;

b.) addressing the increased discharge rates in rural facilities, especially resulting from the greater proportions of elderly persons who are often readmitted shortly after being discharged. In addition, Medicare's Prospective Payment System (PPS) leads to early patient discharges; the swing bed program is a method of providing needed care to such patients;

c.) meeting a previously unmet demand for long term care services in communities where institutional and/or home based care is not readily available;

d.) increasing utilization of certified beds in hospitals experiencing decreasing or fluctuating occupancy rates;

e.) providing long term care more cost-effectively than traditional extended care facilities.

Eligibility for a hospital to provide swing bed care was initially established by the federal Health Care Financing

Administration in July 1982. The hospital must be located in a rural area, which is any area not designated as urban by the most recent census. Moreover, the facility must have fewer than 50 certified beds.* Finally, the hospital must possess a certificate of need (CON) from the State Health Department for the provision of long term care services.

The swing bed concept has been implemented in almost 1000 rural hospitals in 40 states. (The following two pages contain a list of those states.) However, it has not been seriously considered for rural hospitals in New York State, regardless of the many benefits that have been reported. Such a program in NYS would re-establish the community hospital as a vital part of the rural economy, meet a demand for services which is not currently being adequately addressed, and promote the efficient use of existing resources.

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*There is currently a move in Congress to increase the threshold to 150 beds.

Table 1: Distribution of Approved Swing-Bed Hospitals by State, January 1987

State	Number of Hospitals Approved for Swing-Bed Care								
	12/31/83	3/31/84	7/31/84	10/31/84	12/31/84	7/31/85	12/31/85	7/31/86	12/31/86
Alabama	0	0	0	0	0	0	1	10	11
Alaska	1	1	1	2	2	6	7	8	8
Arizona	0	4	6	6	6	6	7	6	6
Arkansas	1	1	5	8	16	25	26	30	30
California	3	3	4	5	6	6	10	9	7
Colorado	2	9	13	15	16	23	25	26	28
Connecticut	0	0	0	0	0	0	0	0	0
Delaware	0	0	0	0	0	0	0	0	0
D.C.	0	0	0	0	0	0	0	0	0
Florida	0	0	0	0	0	0	3	4	5
Georgia	0	3	4	5	6	9	15	17	18
Hawaii	2	2	2	2	2	1	1	0	0
Idaho	3	3	4	4	4	9	10	12	13
Illinois	0	1	2	5	8	16	18	18	18
Indiana	1	1	2	2	2	4	4	5	5
Iowa	33	37	44	44*	86	92	92	94	91
Kansas	7	10	16	16*	40	63	66	78	80
Kentucky	1	0	1	1	1	1	1	1	4
Louisiana	0	0	0	1	1	4	9	22	22
Maine	0	0	0	0	0	0	0	0	0
Maryland	0	0	0	0	0	0	0	0	0
Massachusetts	0	0	0	0	0	0	0	0	0
Michigan	0	0	0	0	0	0	0	0	0
Minnesota	3	4	24	56	63	79	82	83	86
Mississippi	4	4	4	4	8	30	34	34	38
Missouri	7	13	16	15*	32	44	46	46	45
Montana	9	13	17	19	20	26	29	30	30
Nebraska	5	3	5	5*	14	36	47	54	57
Nevada	4	4	4	4	4	3	7	6	6

Table 1: Distribution of Approved Swing-Bed Hospitals by State, January 1987

State	Number of Hospitals Approved for Swing-Bed Care								
	12/31/83	3/31/84	7/31/84	10/31/84	12/31/84	7/31/85	12/31/85	7/31/86	12/31/86
New Hampshire	2	2	2	2	2	2	2	7	7
New Jersey	0	0	0	0	0	0	0	0	0
New Mexico	8	8	8	9	9	13	13	13	13
New York	0	0	0	0	0	0	0	0	0
North Carolina	1	4	7	7	7	8	13	16	19
North Dakota	14	20	20	21	21	29	29	29	29
Ohio	0	0	0	2	2	2	2	2	5
Oklahoma	1	1	1	1	4	13	18	25	29
Oregon	0	0	0	0	0	0	0	0	1
Pennsylvania	0	0	0	0	0	0	1	1	1
Rhode Island	0	0	0	0	0	0	0	0	0
South Carolina	0	0	0	0	0	7	11	11	13
South Dakota	19	20	21	22	23	27	27	29	32
Tennessee	0	1	1	3	3	7	10	11	18
Texas	2	2	4	8	17	26	29	65	79
Utah	7	7	7	8	8	10	9	12	11
Vermont	0	0	0	0	0	1	1	2	3
Virginia	0	0	0	0	0	0	0	1	1
Washington	2	5	8	8	9	10	12	15	15
West Virginia	0	0	0	0	0	0	1	3	3
Wisconsin	6	7	15	16	24	38	42	52	56
Wyoming	1	5	5	5	5	12	11	12	13
TOTAL	149	198	273	331	471	688	771	899	956

*These counts are based on August 1984 data

Source: Compiled by the Center for Health Services Research, University of Colorado Health Sciences Center. Data sources are the Survey and Certification Review Branch of each of the ten regional HCFA offices.

CAPITAL FINANCING ISSUES

During discussions at the 1985 Rural Health Care Symposium co-sponsored by the Commission on Rural Resources, as well as in testimony gathered at several public hearings, various individuals involved in rural health care delivery indicated a special need for capital financing. To follow up on what the Commission was hearing, a capital financing survey was sent to 283 rural hospitals and residential health care facilities throughout the state. The criteria used to select health care facilities to survey, were those facilities located in rural counties (county population under 200,000), as well as facilities serving a predominantly rural clientele in more heavily populated upstate counties. The Commission received 88 responses to the questionnaire and has prepared the following summary. Copies of the full report are available from the Commission office.

Health Care Facilities With 100 Beds or Less
(Number of Respondents: 54)

Projects Financed During Past 5 Years

Most financing projects fall into two categories: 1)Equipment purchases or 2)Facility renovation or expansion. Over two-thirds of the projects financed during the past 5 years were for medical, telecommunications or computer equipment, ranging from $10,000 to $300,000 per year. Renovation and expansion projects ranged from $10,000 to several million usually spread over several years. Sources of funds included: Farmers Home Administration (FmHA), Urban Development Action Grants (UDAG), municipal bonds, bond anticipation notes, local bank lending and mortgages, tax exempt Industrial Development Agency (IDA) bonds, NYS Medical Care Facilities Finance Agency (MCFFA) bonds, Housing and Urban Development (HUD) guarantees, manufacturer financing, leasing companies, operating revenues and community fund drives and gifts.

Strengths and Limitations of Current Financing Methods

- The respondents used private sector financing twice as often as public sector funds when making equipment purchases.

- Leasing directly from manufacturers and through banks was the method most often used to finance equipment. Although interest rates tended to be higher with lease arrangements than with other sources of funds, leasing is easy, quick, and the lessors were attentive and accommodating in most cases.

- FmHA loan programs were the most often used programs for large scale renovations and expansions due to low interest rates and favorable lending terms. The future of this well-utilized program is in question because the President's FY 88 budget did not include funding for FmHA rural development programs. Congress will probably reinstate funds for this program but not at the 476 million dollar level funded most recently.

- A general complaint of FmHA, UDAG and other public sector funds was the amount of time and paperwork involved in gaining approval. It appears that health facility administrators are willing to pay higher finance charges in order to secure more favorable terms and to avoid lengthy delays and the general bureaucracy involved in receiving public monies.

Projects Anticipated for Next 5 years

Over 75 percent of the respondents identified equipment or renovation projects they intended to undertake in the next 5 years. Most of these projects have sources of funds identified, although the actual source often changes by time the project is undertaken. Smaller hospitals and nursing homes were less definite in the projects they anticipated as well as in identifying sources of capital.

Suggestions to Improve Capital Financing

Recommendations for improving capital financing proposed by survey respondents include the following:

- It is extremely difficult for small facility administrators to follow and understand the myriad of financing options and regulations. Respondents suggest periodic seminars or regional meetings of administrators and public officials be held in order to answer financing questions.

- Establish regional capital equipment (new & replacement) acquisition pools providing low cost or interest free capital for projects under $300,000.

- Of the 41 administrators of facilities under 100 beds who answered a question on MCFFA, 59 percent indicated they were "not aware that MCFFA exists to serve my institution." They suggested: "newsletters should be sent from MCFFA describing the advantage of financing with them. We receive calls and letters on a monthly basis from other financing agencies."

- Receiving Health Department certificate of need (CON) approval is currently a very time consuming and frustrating process, especially for small providers. Respondents suggested that the approval process be revamped to facilitate quicker turnaround of proposals after they are submitted, which should include raising thresholds for review to allow the approval of routine equipment purchases.

- Respondents reported a general lack of direction by the State Health Department. Department regulations and policies often place severe financial burdens on facilities that weakens their financial position and makes the facility unattractive to commercial lenders and other sources of capital.

Health Care Facilities With More Than 100 Beds

(Number of Respondents: 34)

Projects Financed During Past 5 Years

Respondents in this group of larger facilities also indicated that two-thirds of their financing needs were for medical, computers or telecommunications equipment. Over 80 percent of the financing for this equipment came from capital leases with manufacturers, banks and leasing companies. Fewer facilities in this group reported undertaking expansion or renovation projects than those with under 100 beds.

Strengths and Limitations of Current Financing Methods

- Twenty-eight respondents answered the question inquiring of their knowledge of MCFFA, with 64 percent indicating they were aware of the agency. However, the program received criticism for a lengthy, cumbersome and complicated application process, and overly restrictive escrow and liability requirements. "The ability to issue tax exempt debt through MCFFA is very attractive. However, the restrictions on future capital replacements are so helplessly bureaucratic that it makes the agency unpalatable."

- Debt servicing under NYPHRM and NYPHRM II was also reported to be too restrictive.

Suggestions to Improve Capital Financing

Respondents made the following recommendations:

- A capital bond pool separate from urban/surburban institutions should be established, which could be drawn on by rural institutions on a revolving line of credit basis.

- A larger share of MCFFA funding should be specifically allocated for financially distressed institutions with limited credit and borrowing capabilities.

- Improved reimbursement of operating expenses; guaranteed reimbursement to cover approved capital projects.

FEDERAL AND STATE AGENCIES AND INTEREST GROUPS THAT IMPACT RURAL HEALTH

The following section shows a listing of state and federal agencies, and industry trade associations a rural New York health care facility could expect to deal directly with or be directly influenced by. An often repeated complaint of rural officials is the sheer number of agencies with which one has to work in order to receive approval for a project, or to solve problems or complications. The great number of executive, legislative and state agencies, each having particular regulations and requirements, means much of the already limited professional staff time in rural facilities is spent in just reacting to regulations.

- Governor's Office:
  - Office for the Aging (25 members - 1 rural)
  - State Board of Social Welfare (15 members - 0 rural)
  - Office of the Advocate for the Disabled (21 - 2 rural)
  - State Commission on Quality of Care for the Mentally Disabled (3 - 0 rural)
  - Disaster Preparedness Commission (members consist of state agency officials)
  - Health Care Financing Council (15 - 1 rural)
  - Select Commission on the Future of the State-Local Mental Health System (members consist of public and private sector health care officials)

STATE LEGISLATURE:

- New York State Senate Standing Committees:
  - Aging
  - Alcoholism and Drug Abuse

  - Mental Hygiene
  - Social Services
  - Insurance
  - Child Care
  - Finance
  - Transportation
  - Education

- Senate Select and Special Committees:
  - Select Committee on the Disabled
- New York State Senate Research Service
- New York State Assembly Standing Committees:
  - Aging
  - Alcoholism and Drug Abuse
  - Health
  - Mental Health, Mental Retardation and Developmental Disabilities
  - Social Services
  - Insurance
  - Children and Families
  - Education
  - Transportation
  - Ways and Means
- Senate - Assembly Commissions:
  - Council on Health Care Financing
  - Commission on Rural Resources

DEPARTMENT OF HEALTH COUNCILS AND COMMITTEES

- Public Health Council (14 members - 1 rural)
- State Hospital Review and Planning Council (31 members - 4 rural)
- New York State Advisory Council on Physicians Assistants and Specialist's Assistants (12 - 4 rural)
- Board of Examiners of Nursing Home Administrators (13 - 1 rural)
- New York State Emergency Medical Council (28 - 11 rural)
- State Council on Home Care Services (17 - 1 rural)
- Statewide Health Coordinating Council (23 - 2 rural)

DEPARTMENT OF SOCIAL SERVICES COUNCILS AND COMMITTEES

- Medical Advisory Committee (20 members - 1 rural)

NEW YORK STATE AGENCIES THAT AFFECT RURAL HEALTH DELIVERY

- Department of Health:
    - Executive Division
    - Division of Health Facilities Standards and Controls
    - Division of Administration
    - Division of Program and Policy Development and Evaluation
    - Office of Health Systems Management
    - Division of Health Care Financing
    - Division of Health Care Planning and Resource Management
    - Division of Health Risk Control
    - Division of Community Health and Epidemiology
    - Center for Health Promotion
    - Health Planning Commission
    - Division of Health Manpower
    - Office of Public Health
- Six Regional Health Systems Agencies: (part federal, part state, part local)
- New York State Medical Care Facilities Finance Agency (MCFFA), a public authority governed by a 3 member board of directors
- Office of Mental Health:
    - Support Division
    - Division of Standards and Quality Assurance and Finance
    - Operations Division
- Office of Mental Retardation and Developmental Disabilities
- Office of Advocate for the Disabled
- Office for the Aging
- Division of Alcoholism and Alcohol Abuse
- Department of Education (training and education)
- Department of Environmental Conservation (disposal of hazardous wastes)
- Department of Labor

- State University of New York
  (training and education)
- Department of Transportation
  (health related public transportation)
- Research Foundation for Mental Hygiene
- Department of Public Service:
  - Public Service Commission
  - Commission on Quality Care for the Mentally Disabled
  - Bureau of Patient Abuse Investigations
- Department of Social Services:
  - Division of Medical Assistance
- Department of State:
  - Division of Licensing
  - State Building Code

Federal Government Agencies that Affect Rural Health Delivery

- Department of Health and Human Services
- Public Health Service
- Social Security Administration
- Human Nutrition Information Service
- Economic Development Administration
- Department of Housing and Urban Development
- Occupational Safety and Health Administration
- Health Care Financing Administration
- Office of Human Development Services
- Department of Transportation
- Department of Commerce
- Department of Agriculture
- Numerous Presidential and Congressional task forces and health care committees

Health Care Associations and Related Interest Groups in NYS

- Family Planning Advocates of New York State, Inc.
- Home Care Association of New York State, Inc.
- Medical Society of New York State
- New York Association of Private Hospitals, Inc.
- New York State Health Facilities Association
- New York Association of Adult Homes, Inc.
- Health Insurance Association of America
- New York State Society of Physicians Assistants
- New York Public Health Association
- Hospital Trustees of New York State
- Hospital Association of New York State
- Central New York Hospital Association
- Greater New York Hospital Association
- Northern New York Hospital Association
- Northeastern New York Hospital Association
- Nassau - Suffolk Hospital Council
- Northern Metropolitan Hospital Association
- Rochester Region Hospital Association
- Western New York Hospital Association
- New York State Association of Counties
- New York State Association of Towns
- New York State Conference of Mayors
- New York State School Boards Association
- New York State Rural Schools Program
- New York Association of Homes and Services for the Aging
- New York State Academy of Family Physicians

- New York Public Welfare Association
- Area Offices for the Aging
- New York State Public Health Association
- Statewide Senior Action Council
- The Business Council of New York State
- Business Group on Health
- New York State HMO Conference
- New York State Association of HSA's

Sources: New York Legislative Manual 1984-1985;
Statewide Telephone Directory

SUMMARY OF PROGRAMS ADMINISTERED BY THE STATE HEALTH DEPARTMENT THAT MAY APPLY TO RURAL AREAS

1. Primary Care Initiative

The Maintenance Program is designed to ensure continued availability of basic primary health care resources which are currently accessible to underserved populations and/or designated geographic areas of need. The program has two initiatives: funding deficits attributable to providing comprehensive care to medically indigent patients ($100,000 maximum award), and providing financial and technical support to primary health care providers located in designted geographic areas of need which are experiencing financial difficulties which could jeopardize their ongoing existence ($150,000 maximum award).

The Development Program is designed to expand the availability and accessibility of primary care to medically underserved areas and populations. This program also has two initiatives: introducing or expanding primary care services in underserved communities ($250,000 maximum award), and enhancing primary care services for medically indigent populations ($250,000 maximum award). (Bureau of Ambulatory Care Reimbursement (518) 474-4672).

2. The Prenatal Care and Nutrition Program (PCNP) is designed to provide comprehensive prenatal care to low income women without health insurance. The program has two major components: prenatal services and outreach/education. Funding is available for prenatal services to cover the cost of comprehensive prenatal care and is based on the number of visits and services to eligible women provided over and above services supported by existing subsidies. Applicants must assure that PCNP awards support new services or expand existing services. Separate funding is available for the outreach/education component which is designed to promote early and continuous use of prenatal services among residents of high need areas where accessibility or availability is a problem. (Bureau of Reproductive Health (518) 473-3368).

3. Nutritional Assistance - The Supplemental Food Program for Women, Infants and Children (WIC) is a state and federally funded program that supplies nutritious foods. The program is targeted to infants, children under age 5, and pregnant or breastfeeding women who are documented to be at nutritional risk. The Supplemental Nutrition Assistance Program (SNAP) is designed to provide nutritional services to the non-institutionalized at-risk elderly, to the homeless and destitute and to high risk low income pregnant women and adolescents in order to prevent both acute and long term health problems to their offspring. (Bureau of Nutrition (518) 473-8286).

4. The NYS Family Planning Program is designed to support family planning clinics, through use of state, local assistance, and federal funding, in all but one county of the state. The clinics provide comprehensive contraceptive care, breast examination, reproductive system evaluation and referral for infertility, screening for cervical cancer, sexually transmissible diseases and hypertension; nutritional evaluation, counseling and community education programs. Providers also focus on the special needs of teens. Educational programs for teens and parents of teens have been developed and presented in schools, churches and community settings. The program also supports the concept of "Women's Health Care Centers" where providers place strong emphasis on the use of nurse practitioners. (Bureau of Reproductive Health (518) 473-3368).

5. The Adolescent Pregnancy Program assists pregnant and at-risk teens to become productive, independent contributors to family and community. The program ensures, through eight ongoing projects, that pregnant, parenting, and at-risk adolescents receive essential health and social services through a referral and follow-up system of case management. (Bureau of Reproductive Health (518) 473-3368).

6. The Primary and Preventive Care for Children Birth - 5 Years of Age is a demonstration program designed to provide outreach, preventive and primary care services, parent education and counseling, and linkage of services to other health and social services programs for children 0-5 years of age. The program is designed to promote the health and well-being of young children by reducing preventable causes of childhood morbidity and mortality in high risk areas of the state. (Bureau of Child Health (518) 474-3664).

7. The Prevention of Low Birth Weight Program funds projects to provide intensive prenatal care services to women at risk for pre-term delivery through screening and treatment. There also is a component focused on adolescents in which coordinating agencies, through a referral and follow-up system of case management, assure the availability of pregnancy testing and family planning services, primary and preventive health care, pediatric care, sexuality and family life education, parenting training and related support services. (Bureau of Reproductive Health (518) 473-3368).

8. The Migrant Health Services Program is designed to support medical and dental services for migratory workers and their families while in New York State. (Field Operations Management Group (518) 473-3394).

9. The Childhood Lead Poisoning Prevention Program is designed to enable county health departments to implement comprehensive programs of screening, diagnosis, medical management and education and environmental follow-up. (Bureau of Child Health (518) 474-3664).

10. The Rural Health Network Demonstration Program is designed to support demonstration projects that improve the delivery of rural health services through the development of cooperative service networks. (Bureau of Health Planning and Policy Development (518) 474-5565).

11. The Hypertension Program provides high blood pressure screening, referrals, follow-up and treatment. (Bureau of Adult and Gerontological Health (518) 474-0512).

12. The Diabetes Control Program offers outpatient education, disease surveillance, and retinopathy intervention services. (Bureau of Adult and Gerontological Health (518) 474-0512).

13. Infant Health Assessment Program (IHAP) provides screening, diagnostic and treatment services to infants and young children at high risk of physical and developmental disabilities. A registry is maintained for follow-up home visits and developmental assessments by the public health nursing staff, medical management, and to provide linkage of information among central, regional and local health department offices. IHAP is implemented via 56 county health departments in upstate New York. (Bureau of Child Health (518) 473-3664).

14. Preventive Dentistry for High Risk and Underserved Children provides screening, referral, and low cost preventive dental services to children residing in communities whose populations exhibit a high degree of poverty and an excessive occurence of dental disease. The program activities are carried out by dental hygienists and are linked whenever possible to other health promotion services targeted to children such as WIC, school health programs, and child health clinics. (Bureau of Dental Health (518) 474-1961).

15. Elderly Pharmaceuticals Insurance Coverage (EPIC) program provides prescription drug insurance coverage for New York State citizens, 65 years and over, who are in low income groups but do not qualify for Medicaid coverage. Insurance options are a comprehensive plan or a catastrophic plan, and coverage is extended to both single persons and married couples. (Elderly Pharmaceuticals Insurance Coverage 1-800-332-EPIC).

16. Rural Health Care Services Diversification Program provides funding for diversification and expansion of rural health services in activities including, but not limited to, primary care, long term care, geriatric services and the affiliation and/or merger of two or more providers. (Bureau of Health Facility Planning (518) 473-4705).

FUNDING SUMMARY FOR GRANT PROGRAMS ADMINISTERED BY THE NEW YORK STATE DEPARTMENT OF HEALTH

Program	Funding	
	SFY 87	FFY 87
Primary Care Inititative	$ 5.M	
Prenatal Care and Nutrition	$17.5M	
Nutritional Assistance		
- WIC	28.7M	$138.4M
- Frail Elderly	9.8M	
- Homeless	4.5M	
NYS Family Planning	10.2M	7.1M
Adolescent Pregnancy	1.3M	1.5M
Primary and Preventive Care for Children Birth to Five Years of Age	$100,000	$795,620
Prevention of Low Birth Weight		1.8M
Migrant Health Service		$100,000
Childhood Lead Poisoning Prevention		1.6M
Rural Health Network Demonstration	$534,000	
Physically Handicapped Children's Program	4.5M	$400,000
Hypertension	3.M	
Diabetes Control	$266,000	
Infant Health Assessment		1.1M
Rural Health Care Services Diversification Program	1.M	

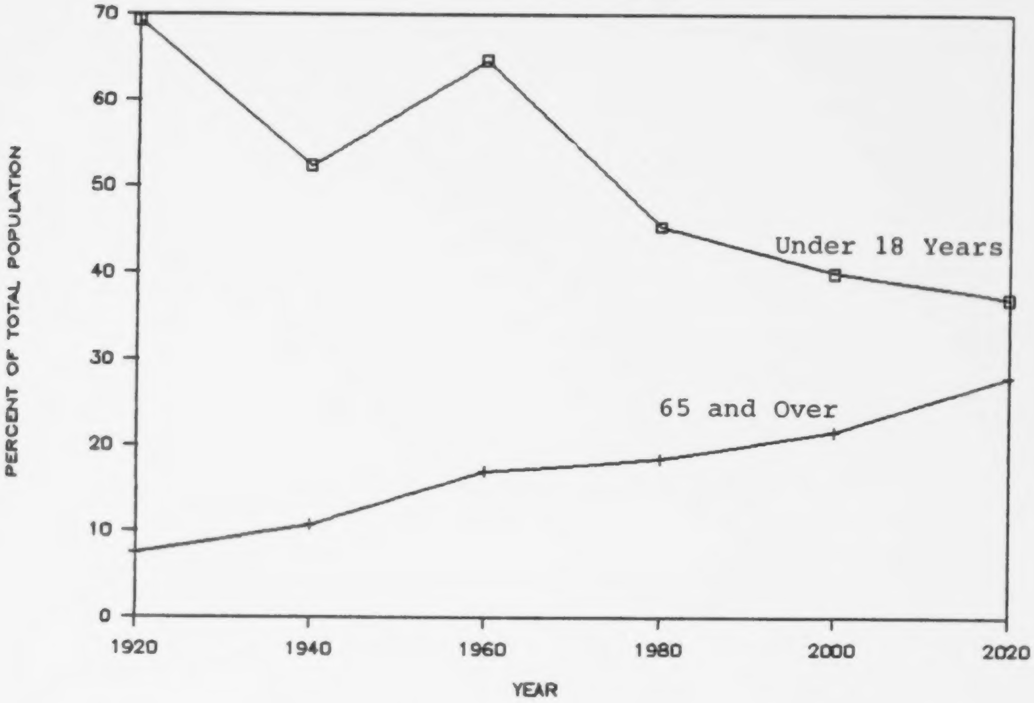
SOURCE: New York State Department of Health

APPENDIX A

SELECTED U.S. FACTS OF INTEREST TO RURAL HEALTH

POPULATION TRENDS OF DEPENDENT GROUPS

1920 - 2020



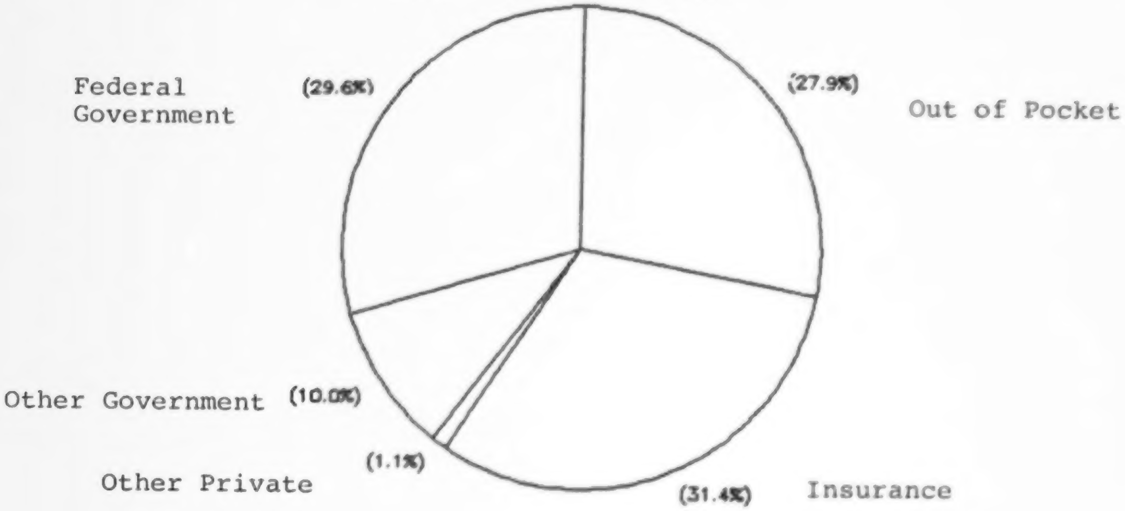
Source: Census Bureau, 1983.

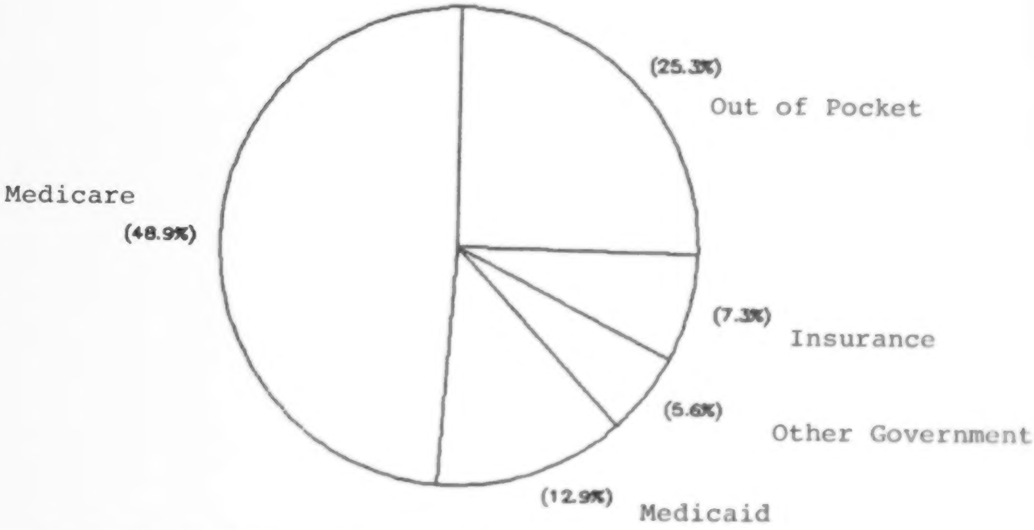
Clearly, the percentage of persons under 18 years old has been (with the exception of 1960), and is expected to continue, decreasing steadily for the time period shown. At the same time, the proportion of the population who are 65 years and over is gradually increasing.

These trends have many important societal implications, including:

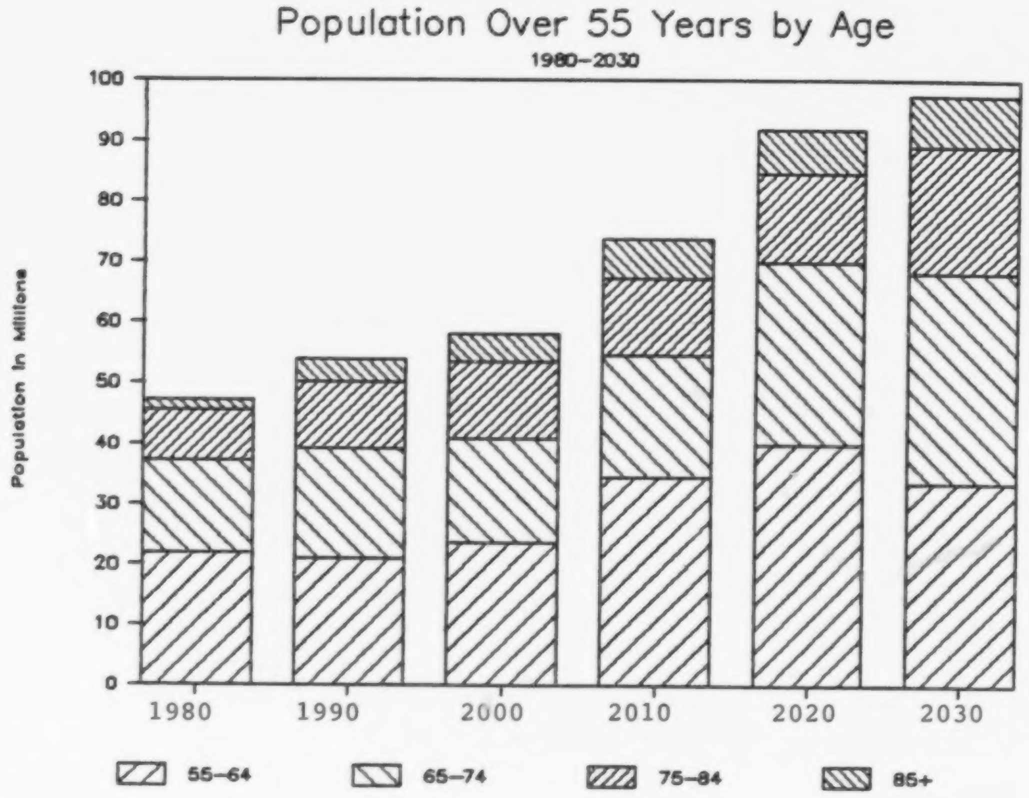
- Although the size of the population under 18 years old -- and dependent upon their parents and other adults for support -- is declining, the proportion of equally dependent elderly persons is increasing, and at a greater rate. Thus, there will be a greater need for public assistance for dependent population groups.
- While the demand for public support gradually increases, the proportion of persons in the workforce is gradually decreasing. Thus, in the future there will be fewer persons working, who are publicly subsidizing the care and support of an increasingly larger dependent population.

Source: Health Care Financing Administration

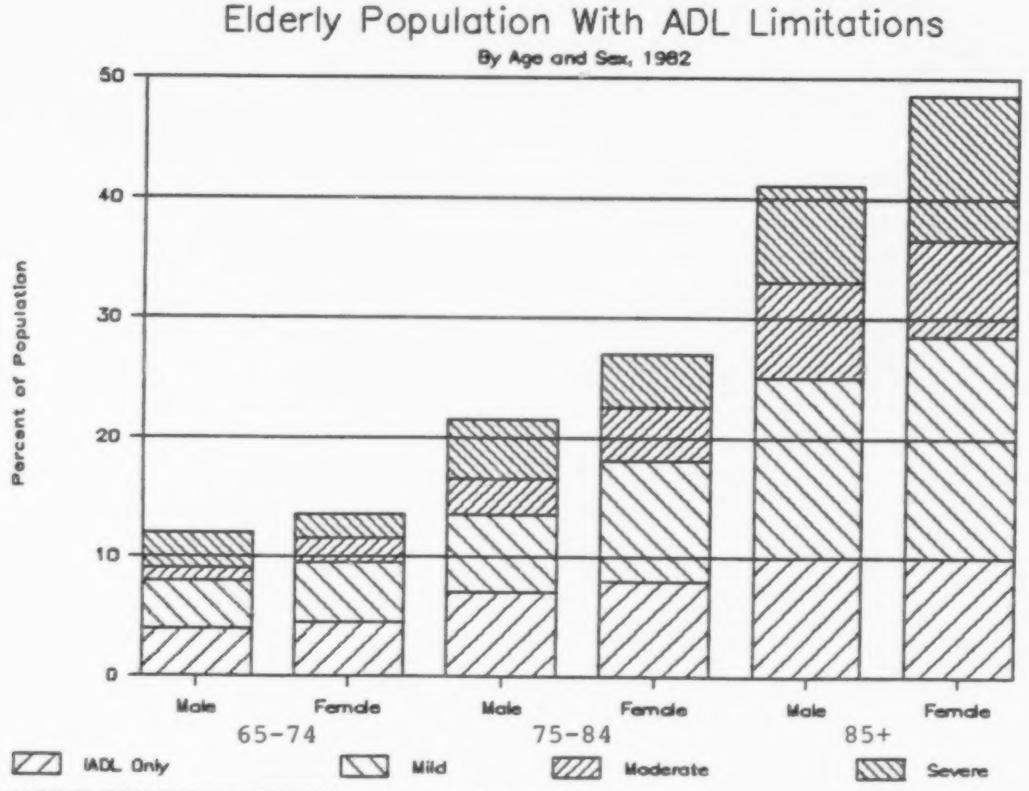

SOURCES OF PERSONAL HEALTH CARE EXPENDITURES
FOR GENERAL POPULATION, 1984
100% = $341.8 Billion


SOURCES OF PERSONAL HEALTH CARE EXPENDITURES
FOR ELDERLY POPULATION, 1984
100% = $119.9 Billion

Source: Health Care Financing Administration


Population Over 55 Years by Age

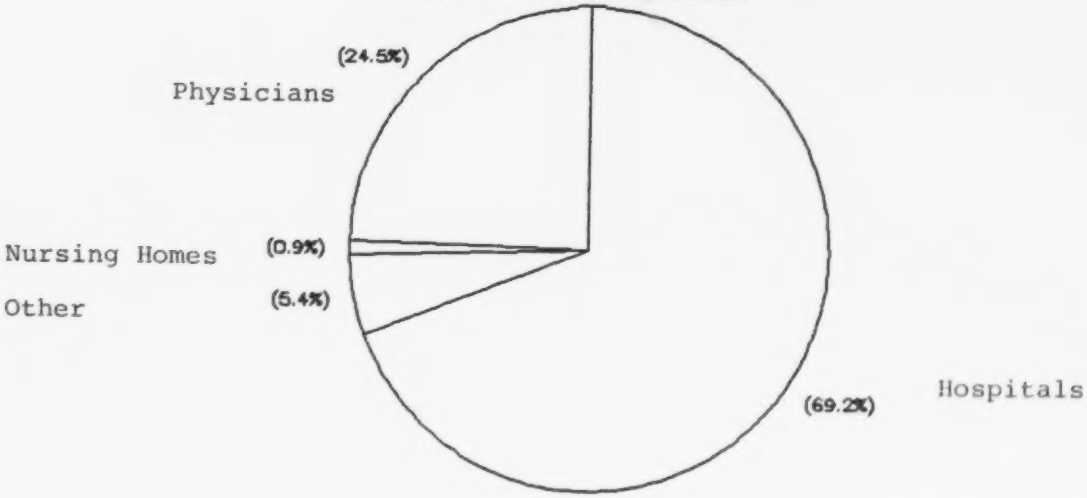
1980-2030


Elderly Population With ADL Limitations

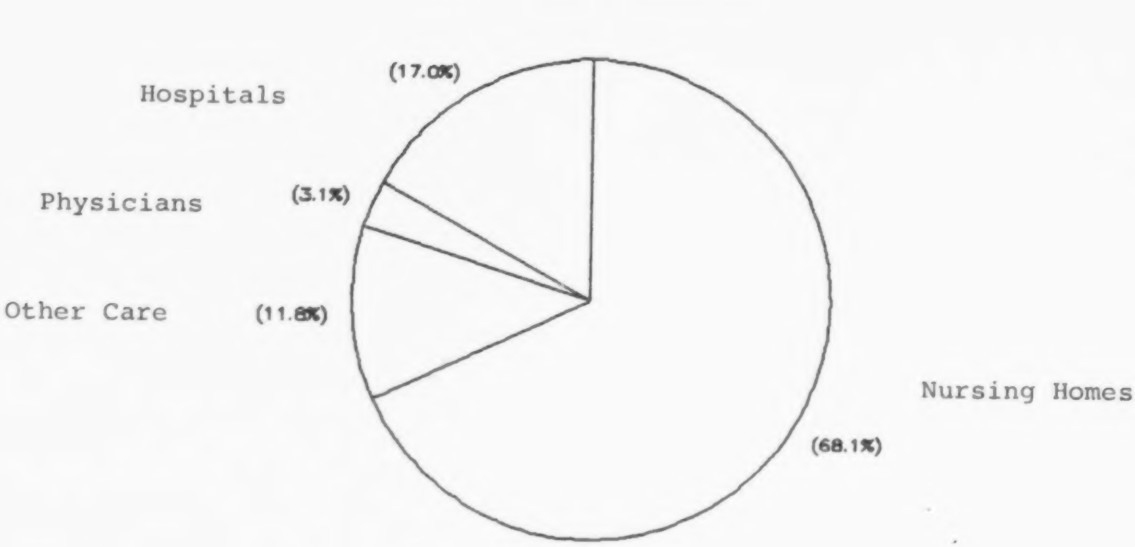
By Age and Sex, 1982

Source: Health Care Financing Administration

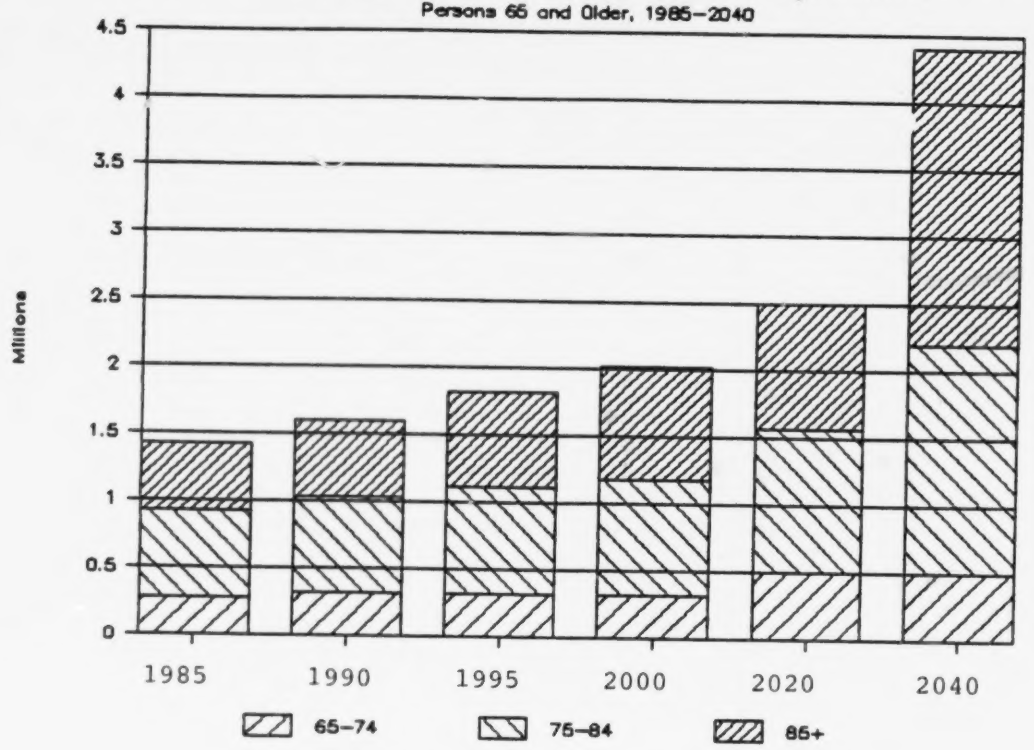
WHERE THE MEDICARE DOLLAR
FOR THE ELDERLY GOES: 1984
100% = $58.5 Billion



WHERE THE MEDICAID DOLLAR
FOR THE ELDERLY GOES: 1984
100% = $15.3 Billion

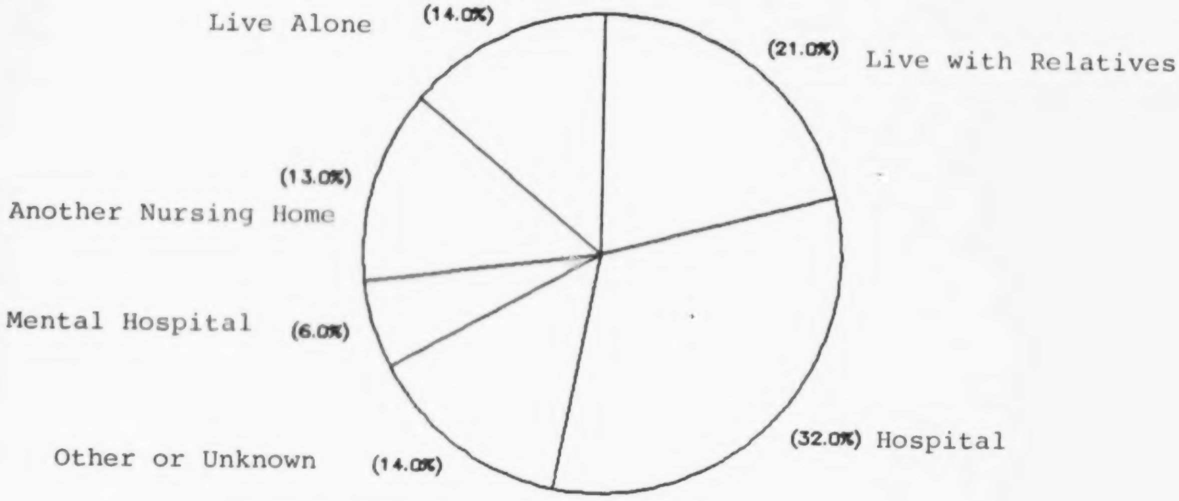


Source: Health Care Financing Administration



Nursing Home Population Projections

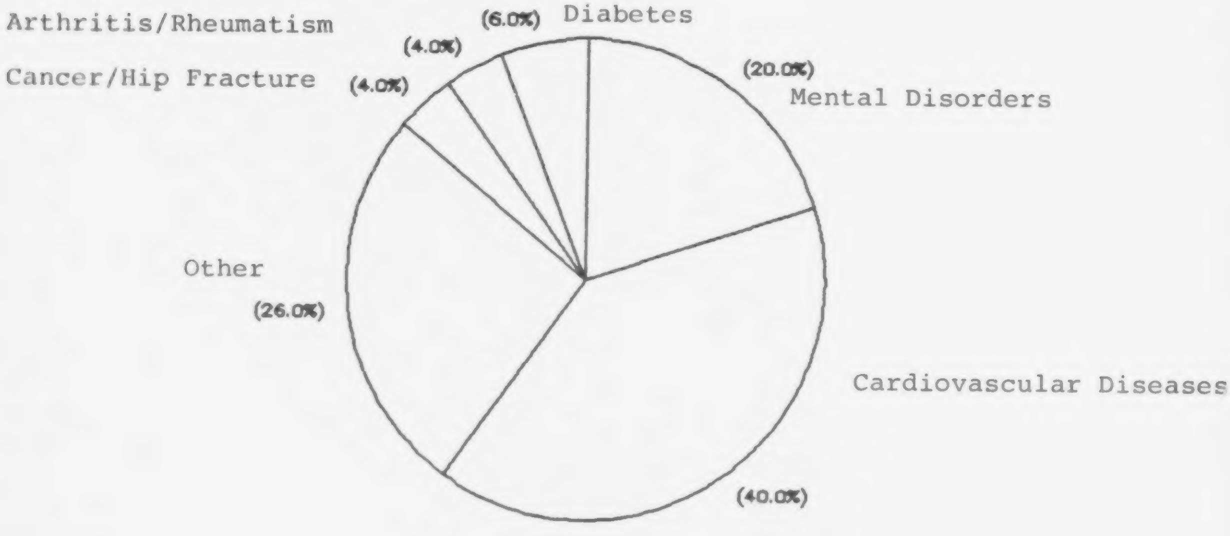
Persons 65 and Older, 1985–2040



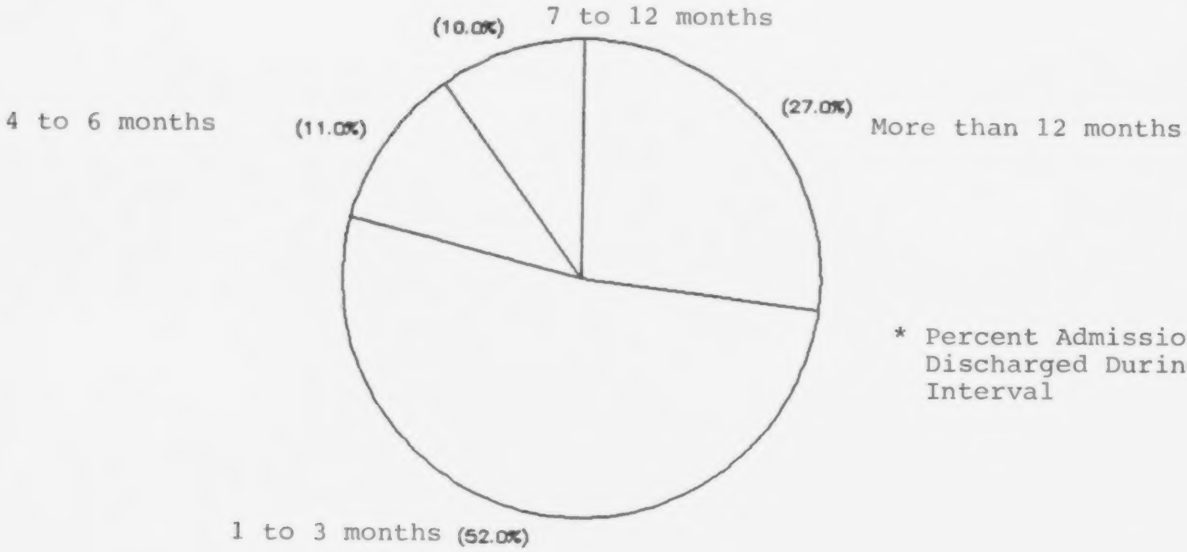
Living Arrangements of Patients
Prior to Admission Into Nursing Home

Source: Health Care Financing Administration

Nursing Home Residents
By Primary Diagnosis on Admission

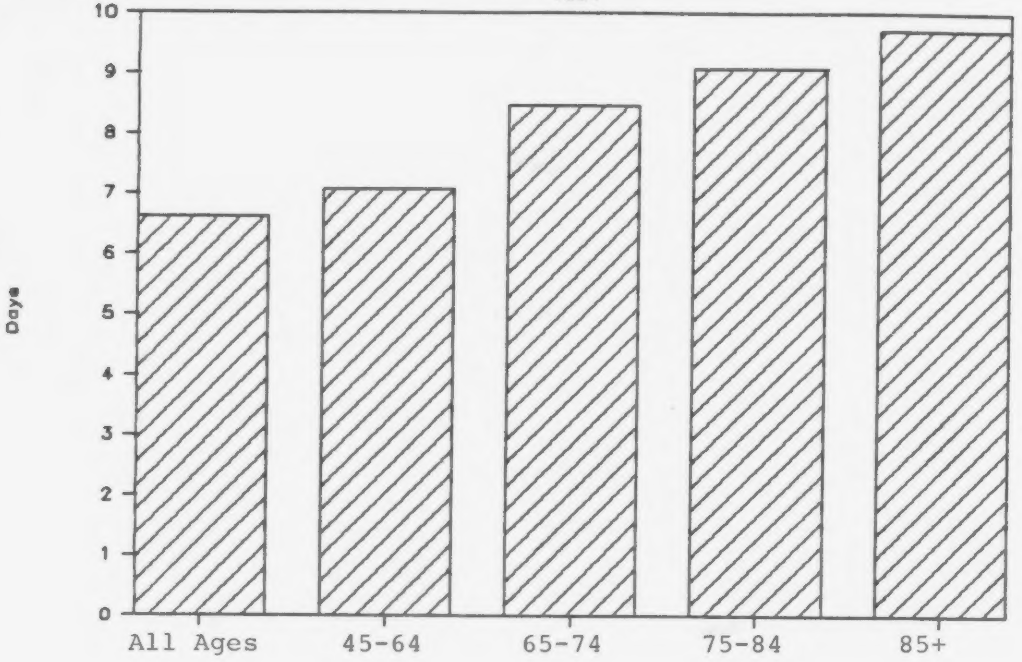


Distribution of Nursing Home Residents
By Length of Stay*



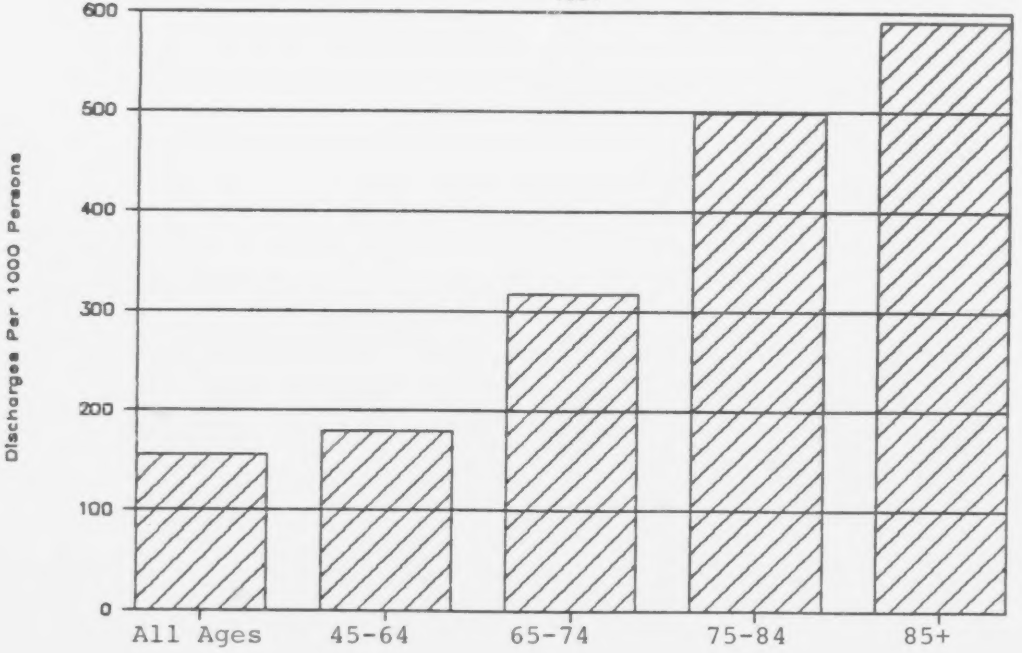
* Percent Admissions
Discharged During
Interval

Source: Health Care Financing Administration



Average Length of Stay by Age Group

1984



Hospital Discharge Rates by Age Group

1984

Source: Health Care Financing Administration

APPENDIX B

SYSTEM DELIVERY ALTERNATIVES IN OTHER STATES

SYSTEM DELIVERY ALTERNATIVES

OTHER STATES

MODEL RURAL HEALTH CONSORTIA

California Rural Health Federation is an association of 33 clinic organizations with about 100 service delivery sites. It was formed over 10 years ago and originally included many federally funded Migrant Health Centers. The federation does not provide clinical services but uses membership dues to provide shared services. The most successful shared service arrangement is for laboratory services. The arrangements for shared laboratory services are being explored by the Northwest Regional Primary Care Association of Seattle for possible implementation through state Primary Care Associations in Idaho and Oregon.

Community Health Clinics, Inc. (CHC) of Parma, Idaho, is a network of five rural clinics operating since 1972 in the agricultural Treasure Valley area (adjacent to Nyssa, Oregon). The nonprofit corporation provides central administrative support to four satellite clinics (physicians and mid-levels) in surrounding rural communities and also administers an Adolescent Health Center. CHC is in the process of establishing a related enterprise that will establish a management support system for a rural consortium of three remote rural clinics in Garden Valley, Horseshoe Bend, and Stanley, Idaho.

Medical Care Development (MCD) of Maine is a federally funded system of eight clinics operating since 1975. Although clinical services are not shared at this time, MCD is the administrative umbrella for the participating clinics. It is responsible for grant preparation, management and reporting.

Nevada Rural Health Consortium (NRHC) is a consortium of eight clinics in seven counties, begun in 1977. Like MCD in Maine, clinical services are not shared. NRHC administers and manages all eight clinics.

Southern Ohio Health Services Network (SOHSN), begun in 1976, manages primary health care service delivery in four rural counties with emphasis in serving the rural poor. The system employs 19 physicians, two dentists and two mid-levels, with the largest center with three physicians and the smallest center with two. Clinical services are provided from each center with SOHSN administering and managing the whole system.

Neighborhood Health Centers of Seattle formed in 1972 and is the only urban model included in the study. It runs six clinics including medical and dental services to mainly low income residents of housing projects in Seattle. There is some sharing of clinical services with administration and management functions being increased through recent reorganization of the governing board.

The Rural Wisconsin Hospital Cooperative began in 1979 between six rural hospitals in a five-county area, and has evolved into three separate organizations with 32 hospital members in a 22-county area. The Hospital Cooperative engages in political advocacy and provides shared services to its members, including legal services, clinical programs, recruitment, and management and clinical training. The two other organizations are the Rural Wisconsin Hospital Trust formed to develop shared insurance for employees, and the HMO of Wisconsin which is an open panel health maintenance organization with 15,000 enrolled members and 1,500 participating physicians (of whom 300 are primary care providers), and includes all 32 hospitals. A rural HMO study is being conducted by Inter-Study under a federal grant to examine seven such HMOs around the United States.

The Eastern Colorado Consortium is a proposed community team approach to addressing problems of health service delivery in the face of local financially troubled hospitals in two geographical areas of rural Colorado. Each area has two counties and three hospitals. The proposal is to perform and in-depth market assessment including a consumer survey. Alternatives are to be explored by holding "town meetings" throughout the area with solutions emerging from this process.

The Virginia Primary Care Association is developing three separate consortia. One of these, the Central Virginia Consortium, proposes to improve perinatal services in its area by sharing obstetrical/gynecological services between a local hospital and health department.

The Southeastern Oregon Rural Health Network was formed between two major rural communities in Klamath County in 1984. Each community has a clinic started under the NHSC program, one with two physicians and the other with a physician's assistant. The proposal is to centralize and share selected administrative and management functions to improve efficiency. These shared management services would be mainly grantsmanship, fund raising and financial management. A broader range of services including nutrition and outreach would be provided under contract with the county health department. Establishing satellite clinic services in other rural communities in the county is to be undertaken.

Extracted from: *Strategic Plan: Primary Health Care in Rural Oregon.* State Health Planning and Development Agency. September, 1985.

AFFORDABLE RURAL COALITION FOR HEALTH (ARCH)

The Center for Rural Health Services
Policy and Research
University of North Dakota
Grand Forks, North Dakota
(701) 777-3848

A. WHY WAS THE PROGRAM UNDERTAKEN?

The Affordable Rural Coalition for Health (ARCH) project is designed to identify creative community-based solutions to the problems of maintaining rural health care services in a period of tremendous change in the health care field. It is a joint effort of The Center for Rural Health Services, Policy and Research at the University of North Dakota, Grand Forks, N.D.; Lutheran Hospitals and Homes Society of Fargo, N.D., and 16 communities in Colorado, Montana and North Dakota. The ARCH program will be carried out over a four-year period that began in July, 1985.

B. GENERAL DESCRIPTION

The approach used in the ARCH project is based on community organizing principles. It is directed at a restructuring of the role of the small rural hospital, and the community health system of which it is a part, to achieve a community-wide, coordinated, cost-effective health system. The ARCH project seeks to demonstrate ways to preserve the small rural hospital as a community resource.

Both single sites and consortium sites of three or more hospitals have agreed to work with their communities in order to address health needs. The population of the ARCH communities ranges from 935 to 15,602; ten of the 16 communities have a population of 2,500 or less. The number of beds in the participating hospitals ranges from 11 to 92 with 13 of the hospitals having 50 beds or less.

The community organizing approach involves several stages. First, a local community organizing coordinator is chosen who agrees to attend an intensive six-week training session in order to develop communication skills and to learn about community organization theory and methods, health care issues and management techniques, and rural perspective. After completing the training the coordinator returns to the community and initiates the formation of a local ARCH board. The board must include representatives of five community sectors: health, religion, commerce, government and education. It should also include a large diversity of people including male and female, younger people, more experienced people, newcomers to the area and pioneer families from all portions of the service area. The board undergoes a training session which is administered by the local coordinator. The board then assesses community needs and develops a proposal for a local ARCH project to be funded by the Kellogg Foundation. Finally the plan is implemented in the community.

C. ADMINISTRATION/MANAGEMENT

The program is supported by an ARCH Policy Committee consisting of representatives of The Center for Rural Health and the Lutheran Hospitals and Homes Society. Locally the coordinators are responsible for administering the program with the boards they help to establish.

D. FINANCIAL AND REIMBURSEMENT

The W.K. Kellogg Foundation has provided $1.4 million in funding for the four-year program. An additional $1.5 million in matching funds and in-kind contributions will be provided by The Center for Rural Health, Lutheran Hospitals and Homes Society and the 16 participating communities.

E. SHARED SERVICES

The local coordinators have conference calls monthly and are learning to use an electronic bulletin board system in order to share information and to lend personal support to their colleagues.

RURAL REFERRAL CENTER PROVIDES COMMUNITY OUTREACH SERVICES

Lifestyles Unlimited
St. Francis Medical Center
Cape Girardeau, Missouri

Contact person: Jo Ann Moore, Adm.
Telephone Number: (314) 335-1251

Lifestyles Unlimited is a regional health information and referral center serving a 10 county area in Southeast Missouri and Southeast Illinois. While a large number of health services are available in this area, access to these services is often a time consuming and confusing process. Located in a regional shopping mall, this community outreach program serves its rural clientele at all times the mall is open. Although financed as an independent budget by the St. Francis Medical Center, the program nevertheless strives to make creative use of available community resources for many of the services provided.

The center often operates 12 hours a day. A registered nurse is always on duty to help answer health questions and to provide referrals. The center also has a wide variety of health literature available and provides free blood pressure checks. Each month the center focuses on a different health issue. Recently, for example, the issue was heart disease and a display was prepared with the help of the American Heart Association spotlighting this issue. Periodically the center will have screenings in conjunction with the particular health issue in focus. For example, the Pearl Vision Center located in the building set up its equipment outside the center and gave free eye examinations. Another time the Division of the Blind provided free glaucoma screening.

Mall tie-ins is another example of how the center tries to utilize available resources. For instance, when the mall had an auto show the center and Easter Seals highlighted seat belt safety. Various child restrain devices were placed in the cars on display, allowing parents the opportunity to compare models. The center also helped to promote the Red Cross' auto first aid kit.

Another initiative the center has undertaken is known as the mall walk. The mall is opened at seven o'clock each morning so people can walk uninterrupted until the stores open at ten o'clock. Lifestyles Unlimited opens at 8 a.m. every Wednesday to provide walkers with blood pressure monitoring. On the first Tuesday of every month a continental breakfast is held for mall walkers. The Medical Center prepares the meal with low cholestral bread and dietic cookies, etc. and the recipes are provided to the walkers. The mall merchants, however, are the ones who pay for the breakfast, and a volunteer speaker gives a presentation afterwards. One recent talk, for example, was on how to dress appropriately for exercise, and the importance of warming up before and cooling down after exercise.

Every second Wednesday of the month the center sponsors Senior Citizens Activity Day. Once again this is joint production. A local grocery store provides the beverages, advertising is paid for by the mall and mall merchants, and the Medical Center provides the bread stuffs. Breakfast is followed by a 30 minute lecture held in one of the mall's movie theaters. The manager of the movie theater offered to donate its use when the number of those attending the breakfast increased to over 200.

Over the two year period the health information and referral center has been open, it has handled 65,000 visits. Approximately one quarter of the visits each month are new ones. Open an average of 75 hours per week, the center has been very successful. Serving a rural area and rural clientele, the center has made health information and services accessible to many whose needs might otherwise go unmet.

LOCAL STRATEGIC PLANNING FOR RURAL HEALTH SERVICES IMPROVEMENT

RURAL HOSPITAL PROJECT
University of Washington
Department of Family Medicine, Research Section
HQ 30
Seattle, Washington 98195

Contact Person: Bruce Amundson, Director
Telephone Number: (206) 543-2461

Funded by the Kellogg Foundation, the Rural Hospital Project encompasses a 4 state area -- Washington, Alaska, Montana and Idaho. A research team surveyed the 140 rural hospitals in this area with the intention of working with 6 financially distressed ones. A rural hospital was defined as one with under 50 beds. Typically there are long distances between rural hospitals. Out of the 140 hospitals, over 70 indicated that they were in financial distress, and six were eventually chosen for participation in the project.

Most responses to a distressed rural hospital situation tend to be focused and categorical. The Rural Hospital Project, however, offers a broader, more global response. The project seeks to form a collaborative effort between the community, hospital, and other health service providers. The belief is that a community-wide strategic planning process is necessary to insure the viability of the rural hospital. The future of a rural hospital is dependent on the rest of the health system components within a community (i.e., physicians, other health care providers).

The initial step of the project, after the six rural hospitals were chosen, was in each case to 1) do a needs assessment of the people utilizing the hospital (personal interviews were conducted); 2) mail a market survey designed to determine utilization patterns and satisfaction levels; and 3) analyze the hospital's management/administration and financial systems. Even before this, however, the research team entered into a contract with each community. Both the team's and community's responsibilities were spelled out. The project was viewed as a collaborative venture.

Once the information had been gathered, a comprehensive list of the community's strengths and weaknesses was compiled. From a clinical point of view, such a comprehensive data base derived from intensive outside analysis is a necessary prerequisite to undertaking any problem solving action. Outside analysis also helps surface issues that might be too painful for a community to surface otherwise. Examples of such issues include physicians with poor interpersonal skills, authoratative hospital administration, and ineffectual boards of directors.

After the research team and community agreed upon the issues (approximately 20 to 30 issues were raised in each community), the next step was to develop the aforementioned community-wide strategic planning processes. Following this of course is the implementation stage. The research team is currently at these stages in the six rural communities.

Generally speaking, intervention can take one of two forms. First, there are interventions external to the community. Examples of these are regulations placed on the hospital by the Health Department, laws passed by the legislature, utilization rates, and health trends in general. The second type of intervention involves those that the community itself can undertake. It is this type of intervention with which the Rural Hospital Project is primarily concerned.

Data gathered in the project show an outmigration for hospital care in these rural communities of 40 to 60%. Outmigration for ambulatory physician services range from 30 to 55%. The project's director reports that a major issue affecting rural hospitals participating in the program is not dollars, but where those dollars are being spent. For example, do health insurance premiums support local services? Health insurance premiums are paid outside the community but filter back with the utilization of local services.

One potential solution to keeping dollars in the rural community is the use of rural PPOs or HMOs. A PPO (Preferred Provider Organization) or HMO (Health Maintenance Organization) provides a financial incentive to use local practitioners and hospitals. In addition, insurance companies have been willing to write specific policies tailored to an individual community. Based on rural costs alone, these policies are often less expensive than more general policies which are based on urban/rural costs.

Perhaps the most important idea of the Kellogg Foundation's Rural Hospital Project is the notion that rural communities should, and can, take some measure of responsibility for insuring the viability of rural hospitals. Just sitting back and waiting for a legislative body or Health Department in a far off city to save their hospital could one day see communities without a hospital to save. The Rural Hospital Project has shown that involving community leaders, hospital management, and other health service providers in a collaborative effort to enhance the viability of a rural hospital increases community optimism about the future, and gives residents a sense of self-control and self-determination. More importantly, it has been shown that such an approach can work when the required external support and local commitment are brought together in the proper fashion. (This same sort of partnership initiative between a local medical staff, hospital and business community is being supported elsewhere by the Business Alliance of America).

DEVELOPING A CONTINUUM OF SERVICES FOR ELDERLY PERSONS WITH LONG-TERM CARE NEEDS

The Robert S. Flinn Foundation
Pheonix, Arizona

The Phoenix-based Flinn Foundation was established in 1965 by the late Dr. and Mrs. Robert S. Flinn and given the broad mission of improving "the quality of life for the people of Arizona and New Mexico." Its grants have been directed primarily to health-related subjects. Recently the Foundation awarded $650,000 in gratns to provide comprehensive health care and support services to the elderly in New Mexico. These grants were awarded to three not-for-profit hospitals, and extend the program already underway in four Arizona hospitals. Through the grant program the Foundation hopes to demonstrate that hospitals which have historically provided quality inpatient care can effectively take responsibility for the coordination and provision of services for the elderly beyond the hospital walls.

The grant funds will assist the three New Mexico hospitals in developing a continuum of services for elderly persons with long term care needs. A developmental-phase grant will be used initially to recruit experienced professional staff capable of organizing and implementing a hospital-based case management program for the frail elderly. Once the recruiting and startup plans have been completed, the institutions will be eligible to apply for second-phase implementation grants.

The impact of new hospital payment systems has most directly affected the elderly. Shortened lengths of stay for illnesses often result in discharged patients still in need of direct medical care, nursing and rehabilitative services, and home care assistance who must often go without such services, especially in rural areas. At present, the delivery of these services is often fragmented and cumbersome, leaving some elderly without adequate care. The grant program will allow the hospitals to coordinate patient care -- from acute episodic illness requiring hospitalization, to assisting people in their homes and in alternative daycare and residentail settings.

These hospital based programs will respond to the problems of costly and inappropriate institutionalization and the "revolving-door" patient; that is, the elderly patient who is frequently readmitted to the hospital. The coordinated care management will offer frail elderly persons (aged 65 and over) a variety of hospital and community-based services. The projects will provide or arrange for patient assessment, placement and followup; homemaker assistance and home health care; medical equipment; nursing home care, adult daycare or alternative housing arrangements; training and support for family and volunteer caregivers; brokering of community services; and removal of physical barriers from the home. Services will be coordinated with a patient's personal physician.

Research has shown that most elderly persons prefer independence within the community rather than institutionalized long term care. The hospitals in this project believe they can coordinate existing services and fill in the gaps for a balance of psychosocial and medical input to address most, if not all, aspects of the needs of frail elderly in their respective communities. It is expected that by networking and administering these services the facilities can improve the quality of life of this rapidly growing segment of the population.

The hospital's case management team, under the direction of an assistant administrator of behavioral health, will include a medical/social worker and a geriatric nurse practitioner. With the assistance of the New Mexico Hospital Association, the Flinn Foundation invited all of New Mexico's hospitals to submit applications for funding under the program. Application materials required applicants to describe the present array of services provided to elderly patients, unmet needs, and how the hospital planned to meet these needs with grant funds.

The grants were made following a lengthly review process of the applications received. A consultant panel conducted the first screening of applications, and the Foundation's Board of Trustees made the final selection of hospital sites.

ELDERLY CARE PROJECT -- HEMET-SAN JACINTO, CALIFORNIA

The linking of long term and extended home care for the elderly and disabled is a health issue that has received considerable public attention but which is still in its infancy compared to other health service alternatives. As such, current efforts are very exploratory and fragmented, particularly in rural areas. Recognizing the immediate need to improve and integrate long-term health care alternatives within California, the State Legislature in 1986 designated the California Department of Aging as the agency responsible for the development of long term care systems for California's elderly. Following the lead of the state legislature, the Riverside County Board of Supervisors appointed a county Office for the Aging as the agency in charge of developing a strategy for community-based, long term care.

The community received seed money from the state under a pilot program, in order to implement a model long term care program for the elderly and disabled in the Hemet-San Jacinto area. This region was chosen in part because of the following: large senior citizen population; encompasses rural, suburban and urban populations; contains an established consortium senior organization; and availability of nearby geriatric case managment, Alzheimer's support group, a hospice program, social day care, and two public health centers.

The Hemet-San Jacinto program does not provide any physical facilities in which to care for individuals, but administers a series of innovative yet simple programs designed to improve home lifestyles and provide coordinated home health support for the elderly and disabled. The programs include a volunteer system based on a blood bank model to involve active and healthy seniors interested in helping those in need* to participate in the formation of a private foundation, the Greater Riverside County Foundation for Independent Living -- intended to create on-going funding resources to benefit programs and senior center developments in the region. The Hemet-San Jacinto program plans to expand services through the senior consortium (Hemet, Prime of Life, Inc.); they include: expanded individual case management, in-home respite care, intergenerational programs, handicapped companion programs, elderly transportation and emergency food and housing. A marketing effort is planned to increase the number of businesses and seniors participating in the Office for the Aging's Senior Identification/Discount Card Program. A computerized client data bank and resource file available to all state and county agencies will be established within the county Office for the Aging. The county Office for the Aging will work jointly with the Departments of Public Social Services and Health and Mental Health to develop a coordinated process which will reduce duplication and will be client-oriented.

The Hemet-San Jacinto program is fortunate to be located in a region with a large number of existing services available for the elderly and disabled. Despite less favorable circumstances, other municipalities can utilize many of the same types of strategies and components in designing their own extended care plan for elderly and disabled residents.

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*The volunteer system based on the Red Cross blood bank model is a unique idea in itself. In this case the volunteers in the elder and disabled programs earn credits that are "banked" with the long term care program. These credits can be used later in lieu of cash payment for services received by the volunteer.

Networking through Regional Child Health Centers:

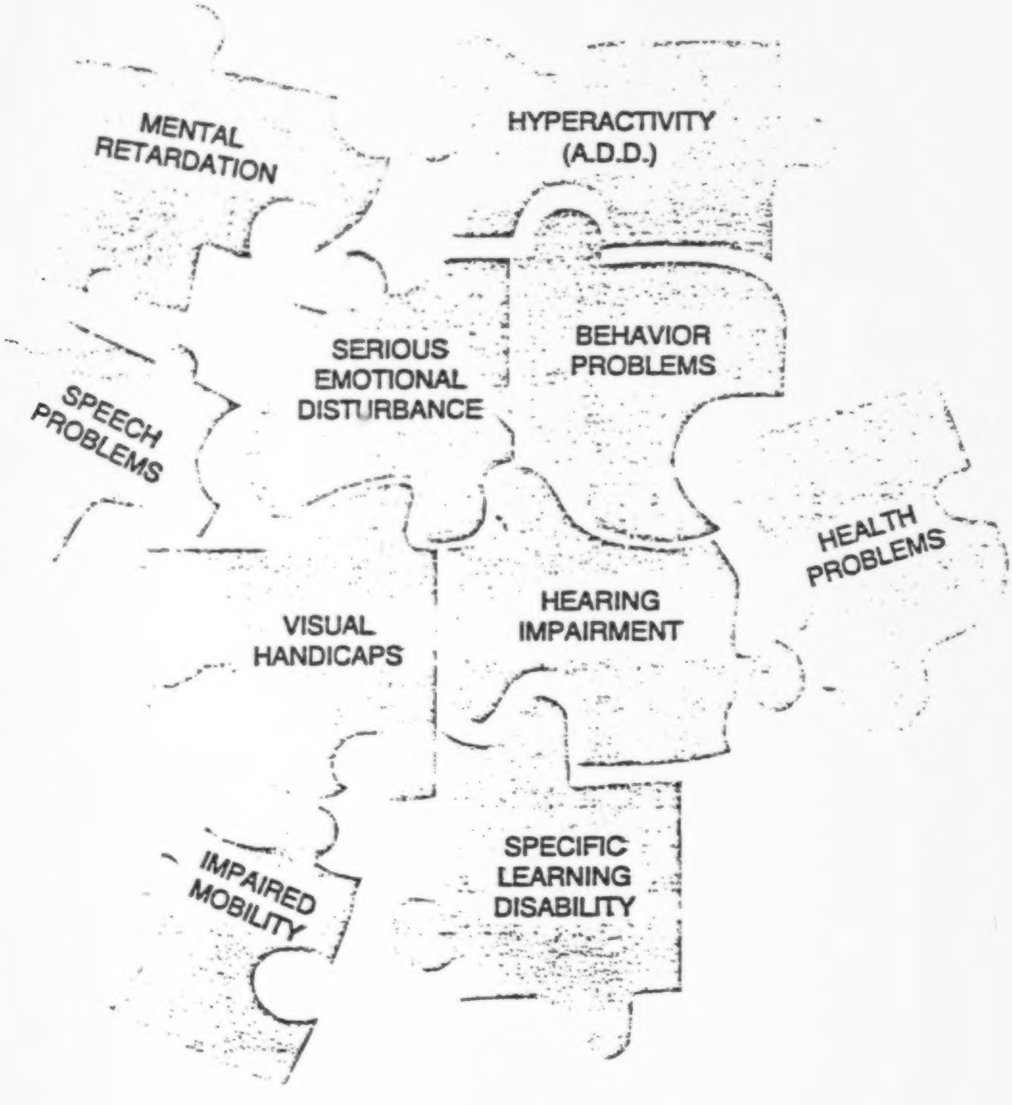
An Alternative Delivery System

CHILD
HEALTH
SPECIALTY
CLINICS

CHSC

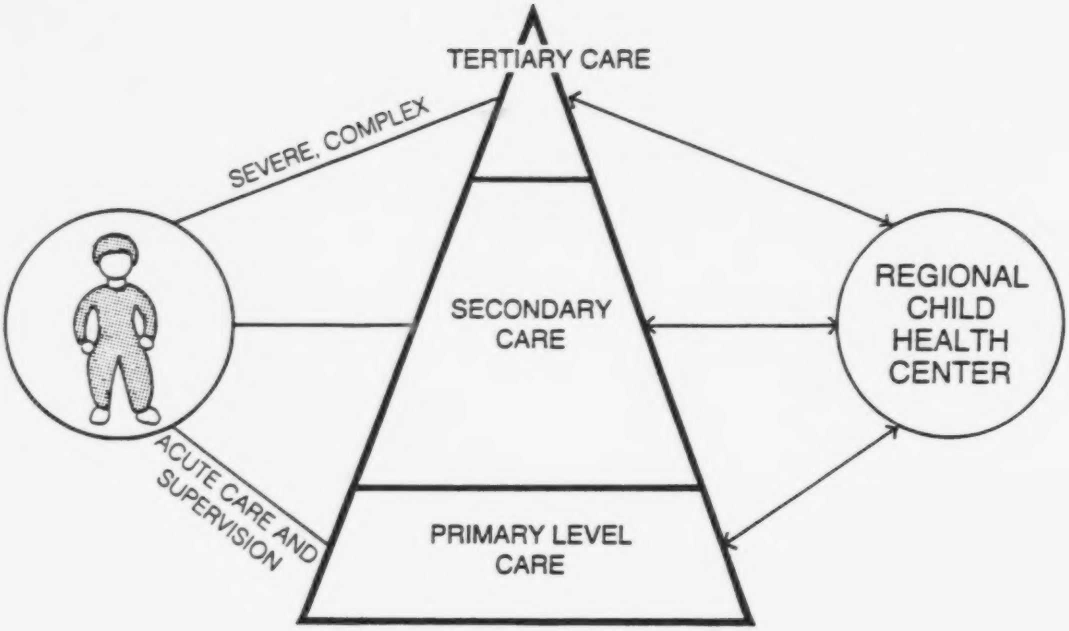
IOWA MOBILE AND REGIONAL
CHILD HEALTH SPECIALTY CLINICS
The University of Iowa
Iowa City, Iowa 52242
(319) 353-5428

Services for children—putting the pieces together

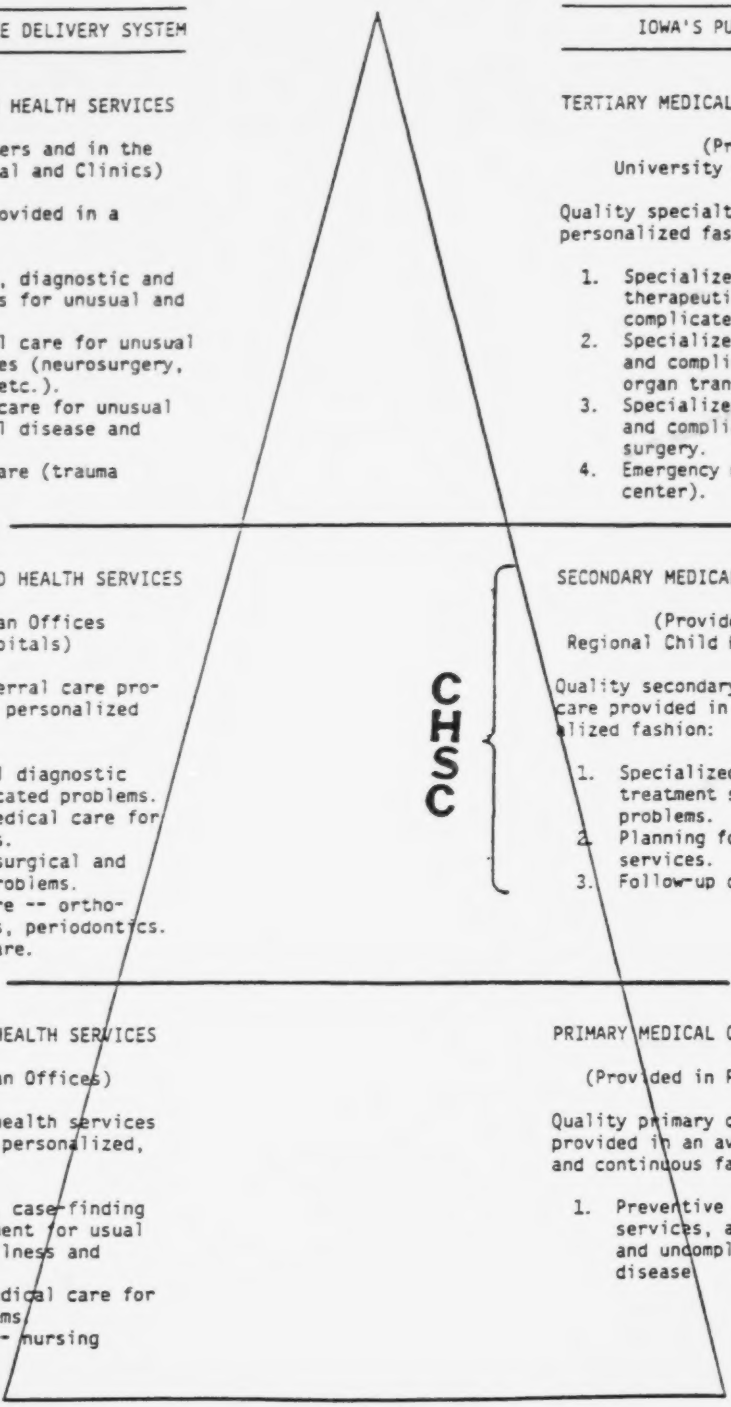

MENTAL RETARDATION
HYPERACTIVITY (A.D.D.)
SERIOUS EMOTIONAL DISTURBANCE
BEHAVIOR PROBLEMS
SPEECH PROBLEMS
HEALTH PROBLEMS
VISUAL HANDICAPS
HEARING IMPAIRMENT
IMPAIRED MOBILITY
SPECIFIC LEARNING DISABILITY

It's a puzzle.

The System of Care for Children


TERTIARY CARE
SEVERE, COMPLEX
SECONDARY CARE
REGIONAL CHILD HEALTH CENTER
ACUTE CARE AND SUPERVISION
PRIMARY LEVEL CARE

The Role of CHSC in Iowa's Medical Care System



IOWA'S PRIVATE HEALTH CARE DELIVERY SYSTEM

TERTIARY MEDICAL CARE AND HEALTH SERVICES

(Provided in Medical Centers and in the University of Iowa Hospital and Clinics)

Quality specialty care provided in a personalized fashion:

1. Specialized medical, diagnostic and therapeutic services for unusual and complicated cases.
2. Specialized surgical care for unusual and complicated cases (neurosurgery, organ transplants, etc.).
3. Specialized dental care for unusual and complicated oral disease and surgery.
4. Emergency medical care (trauma center).

SECONDARY MEDICAL CARE AND HEALTH SERVICES

(Provided in Physician Offices and Regional Hospitals)

Quality secondary and referral care provided in an available and personalized fashion:

1. Medical and surgical diagnostic services for complicated problems.
2. Surgical care and medical care for complicated problems.
3. Services for major surgical and medical emergency problems.
4. Specialty dental care -- orthodontics, endodontics, periodontics.
5. Emergency medical care.

PRIMARY MEDICAL CARE AND HEALTH SERVICES

(Provided in Physician Offices)

Quality primary care and health services provided in an available, personalized, and continuous fashion:

1. Preventive services, case-finding services, and treatment for usual and uncomplicated illness and disease.
2. Minor surgery and medical care for uncomplicated problems.
3. Home care programs -- nursing services.

IOWA'S PUBLIC SERVICE SYSTEM

TERTIARY MEDICAL CARE AND HEALTH SERVICES

(Provided in the University Hospital and Clinics)

Quality specialty care provided in a personalized fashion:

1. Specialized medical, diagnostic and therapeutic services for unusual and complicated cases.
2. Specialized surgical care for unusual and complicated cases (neurosurgery, organ transplants, etc.).
3. Specialized dental care for unusual and complicated oral disease and surgery.
4. Emergency medical care (trauma center).

SECONDARY MEDICAL CARE AND HEALTH SERVICES

(Provided in Mobile and Regional Child Health Specialty Clinics)

Quality secondary and referral ambulatory care provided in an available and personalized fashion:

1. Specialized medical, diagnostic and treatment services for complicated problems.
2. Planning for multiple professional services.
3. Follow-up care management services.

PRIMARY MEDICAL CARE AND HEALTH SERVICES

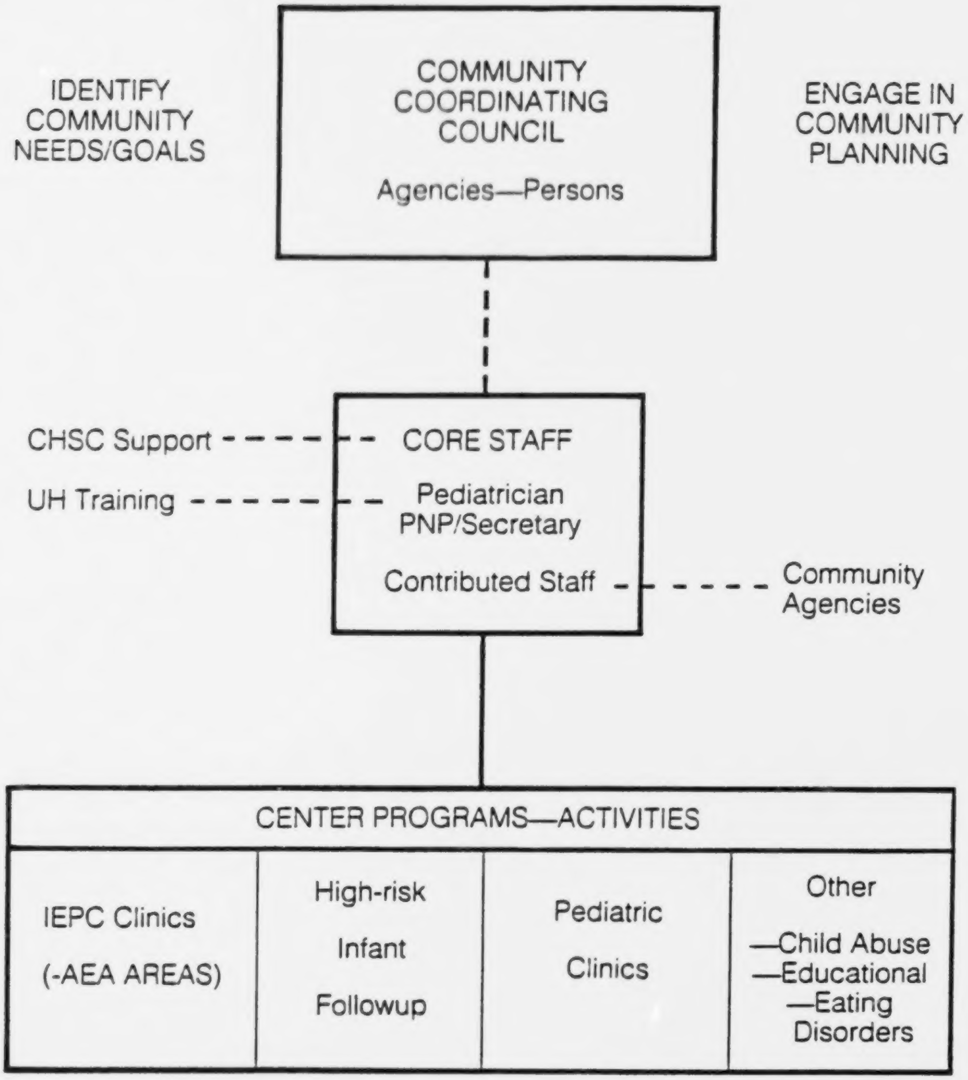
(Provided in Public Health Clinics)

Quality primary care and health services provided in an available, personalized, and continuous fashion:

1. Preventive services, case-finding services, and treatment for usual and uncomplicated illness and disease.

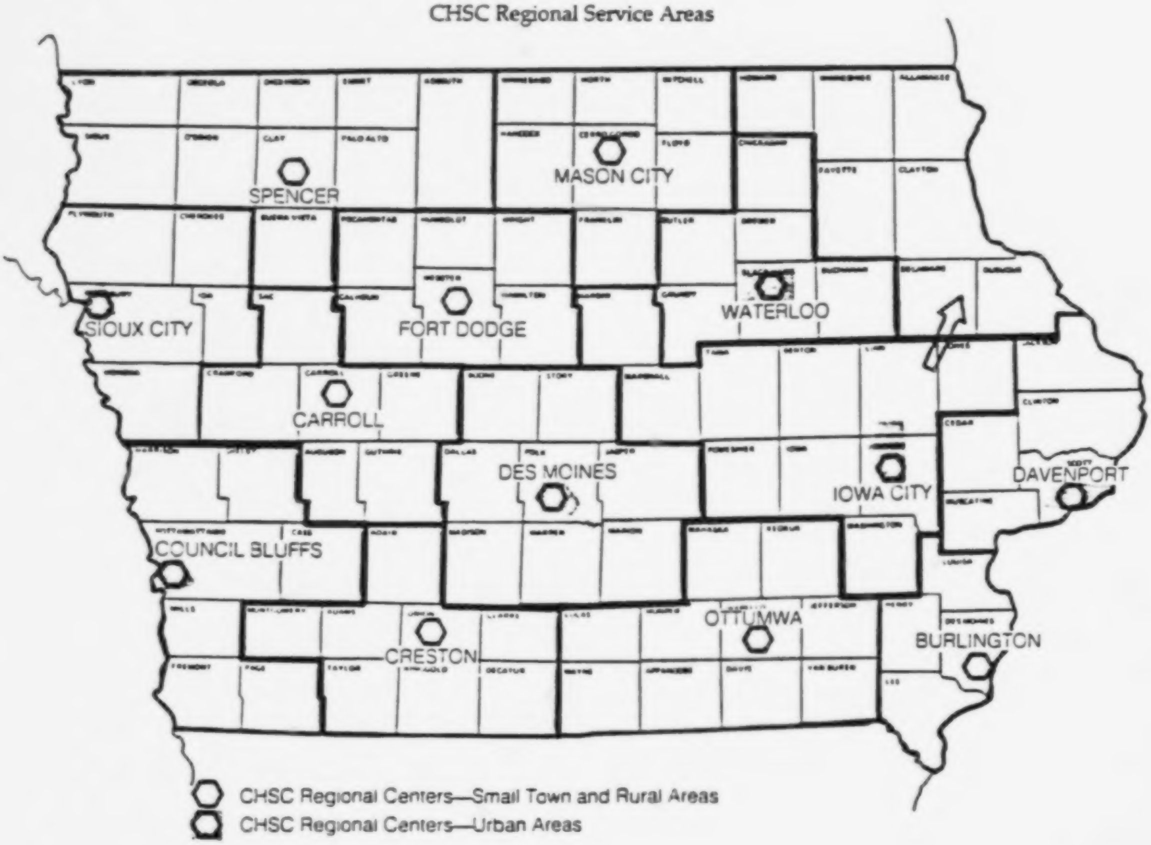
Source: Adapted from State and Planning Area Patterns of Patient Origin and Hospital Utilization, Report of the Office for Comprehensive Health Planning in the Governor's Office for Planning and Programming, June, 1974; and A Proposed Organizational Structure for Providing Health Services and Medical Care in the State of Iowa, John C. MacQueen, M.D., Chairman, Health Manpower Committee of the Iowa Comprehensive Health Planning Council; Associate Dean, College of Medicine, University of Iowa and Eber Eldridge, Ph.D., Professor, Department of Economics, Iowa State University, August, 1972.

The Regional Child Health Center

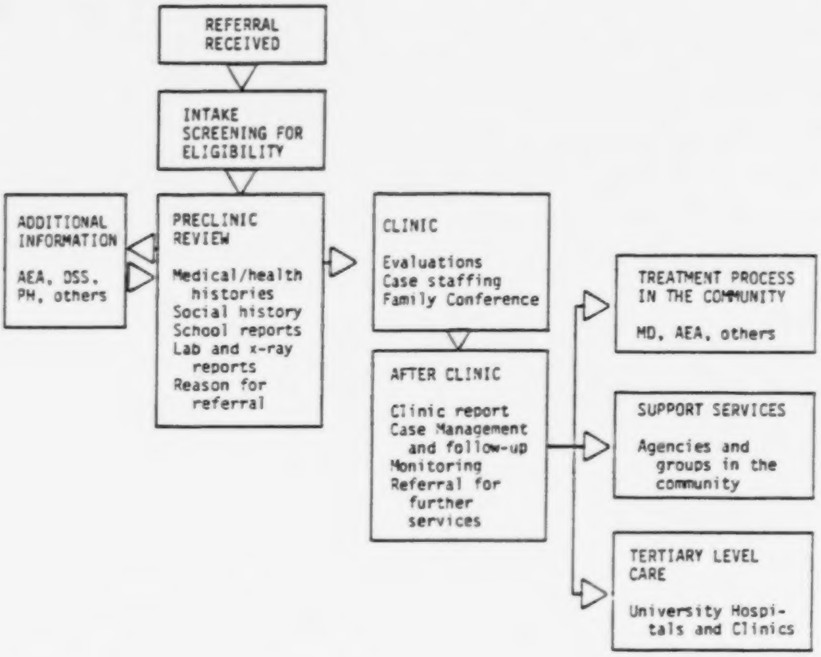

IDENTIFY COMMUNITY NEEDS/GOALS
COMMUNITY COORDINATING COUNCIL
Agencies—Persons
ENGAGE IN COMMUNITY PLANNING
CHSC Support
UH Training
CORE STAFF
Pediatrician
PNP/Secretary
Contributed Staff
Community Agencies
CENTER PROGRAMS—ACTIVITIES
IEPC Clinics
(-AEA AREAS)
High-risk
Infant
Followup
Pediatric
Clinics
Other
—Child Abuse
—Educational
—Eating Disorders

In 1977, the Office of Maternal and Child Health and the Office of Special Education and Rehabilitative Services (U.S. Department of Education) requested grant applications for the development of integrated systems of services for children with combined educational and health problems provided by the combined efforts of state educational and state health agencies. A five-year grant was awarded to Iowa to begin the project. Later, additional funding from the Iowa State Legislature provided the basic support to enable this agency to expand and develop a comprehensive statewide system of regional centers.

CHSC Regional Service Areas


SPENCER
MASON CITY
SIOUX CITY
FORT DODGE
WATERLOO
CARROLL
DES MOINES
IOWA CITY
DAVENPORT
COUNCIL BLUFFS
OTTUMWA
CRESTON
BURLINGTON
CHSC Regional Centers—Small Town and Rural Areas
CHSC Regional Centers—Urban Areas

There are now 12 such centers functioning in Iowa. The centers are community-directed coalition efforts, functioning on a secondary level as a part of a stratified system of health care. They provide diagnostic services, Integrated Evaluation and Planning Clinic Process


REFERRAL RECEIVED
INTAKE SCREENING FOR ELIGIBILITY
ADDITIONAL INFORMATION
AEA, DSS, PH, others
PRECLINIC REVIEW
Medical/health histories
Social history
School reports
Lab and x-ray reports
Reason for referral
CLINIC
Evaluations
Case staffing
Family Conference
AFTER CLINIC
Clinic report
Case Management and follow-up
Monitoring
Referral for further services
TREATMENT PROCESS IN THE COMMUNITY
MD, AEA, others
SUPPORT SERVICES
Agencies and groups in the community
TERTIARY LEVEL CARE
University Hospitals and Clinics

Summary of Characteristics of the Services Provided in the Center

- The services are organized to include professional multiple agency participation since many children require multiple professional assistance.

- The services are community based. Although a child may require specialized care, many of the support services needed by these children are generic and can be provided in the community.

- The services are family oriented. Children with chronic illnesses and handicapping conditions particularly need family support and the family needs community support services.

- The services are regionalized. Children with chronic illness and handicapping conditions represent a low-frequency, high-service, high-cost population and experience shows that the only way such services can be made available is by regionalizing those services to conserve resources.

- The services do not destroy the economy of the family. One of the ways of decreasing the costs of services is through the coordination of services.

- The services may well include certain technical care that has been recommended as a result of an examination in a tertiary center. Treatment plans as developed by a tertiary center may include follow-up diagnostic and treatment procedures that can be provided in the community.

- The services include a coordination of services needed by children with behavioral, educational and developmental problems. There is abundant documentation that there is an ever increasing number of children who have been identified as "the new morbidity." These children need access to representatives of education and mental health.

- The services provide family support. It has been documented that many children with chronic illness and handicapping conditions and their families have, over and above their need for technical care, the need for support services. These are for the greater part generic services needed by all children who have chronic illnesses. The organization of these services must be designed in the community by those who are to be involved with the provision of the care.

- The services must coordinate with other contemporary services including a variety of screening programs and early identification programs. Some of these are for targeted populations as the scoliosis screening program or for children who are obese. Some services are for a broad population such as programs for the prevention of sexual abuse.

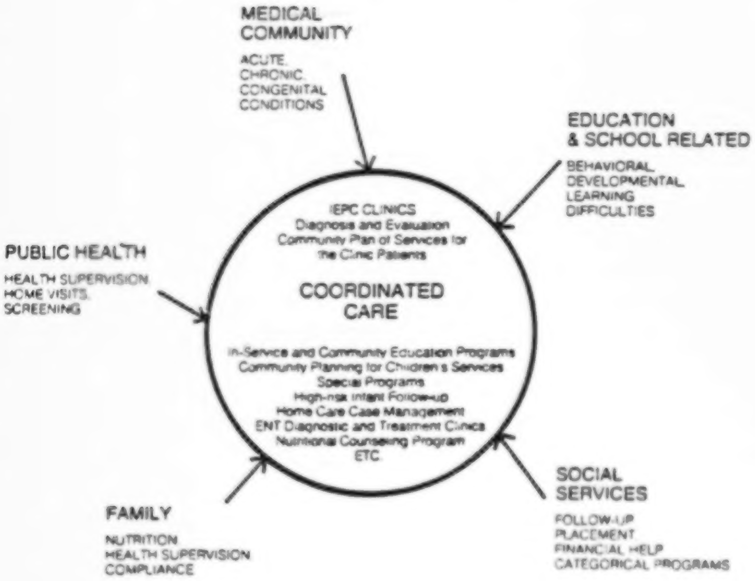
A typical clinic day in which these services are provided can be seen in the following clinic day schedule for the Ottumwa area regional center.

Various specialty health programs have been added to the regional centers beginning with the addition of a statewide high risk follow-up program, and now with the introduction of the home care program for chronically ill and technology-dependent children. Community planning by major agencies and local groups is being carried out. About 83% of Iowa's children in 84 of Iowa's 99 counties have some or all of these services available to them.

Center Organization

It is important to note that operation of the center and its clinics and programs are based on a voluntary coalition of agencies. Each agency commits staff time and resources.

REGIONAL CHILD HEALTH CENTERS
Essentials of the Program
Voluntary Coalition


MEDICAL COMMUNITY
ACUTE,
CHRONIC,
CONGENITAL
CONDITIONS
EDUCATION & SCHOOL RELATED
BEHAVIORAL,
DEVELOPMENTAL,
LEARNING
DIFFICULTIES
PUBLIC HEALTH
HEALTH SUPERVISION
HOME VISITS,
SCREENING
IEPC CLINICS
Diagnosis and Evaluation
Community Plan of Services for the Clinic Patients
COORDINATED CARE
In-Service and Community Education Programs
Community Planning for Children's Services
Special Programs
High-risk Infant Follow-up
Home Care Case Management
ENT Diagnostic and Treatment Clinics
Nutritional Counseling Program
ETC.
FAMILY
NUTRITION
HEALTH SUPERVISION
COMPLIANCE
SOCIAL SERVICES
FOLLOW-UP
PLACEMENT
FINANCIAL HELP
CATEGORICAL PROGRAMS

SUMMARY OF CHILD HEALTH SPECIALTY CLINICS AND PROGRAMS

PATIENT SERVICES

Evaluation & Intervention Services

- High-Risk Infant Follow-up
- Coronary Prevention
- Lead Based Poisoning
- Integrated Evaluation and Planning Clinics
- Ped/Developmental Clinics
- Adolescent Problems
- Orthopedic Clinics
- Ear, Nose and Throat Clinics
- Cardiac Clinics
- Residential Facility Clinics
- Cystic Fibrosis Clinics
- Muscle Disorder Clinics

PATIENT PROBLEMS

- Health Risks
- Delayed Development
- Lost Functions
- Early Disabilities
- Premature Death

FAMILY SUPPORT SERVICES

Case Management Services

- Family Home Care

Financial Support Services

- Sliding Fee Scale
- Purchase of Care
- SSI/Disabled Children's Program
- Transportation

FAMILY PROBLEMS

- Lack of Resources
- Lack of Expertise
- Lack of Written Direction

PROVIDER SUPPORT SERVICES

Professional Training

- Audiology and Speech Pathology Training Program
- Pediatrician and Pediatric Nurse Practitioner Specialty Training Program
- Student Nurse Training
- Provider Inservice Training Program
- Provider Consultations
- Scoliosis Screeners Training

PROVIDER PROBLEMS

- Lack of Special Providers
- Maldistribution of Providers
- Provider Information
- Provider Training

SYSTEMS SUPPORT SERVICES

Service System

- Regional Centers and Clinics
- Integration of Services Sites, Facilities and Staff
- Networking of Services for Handicapped Children
- Interagency Patient Information System

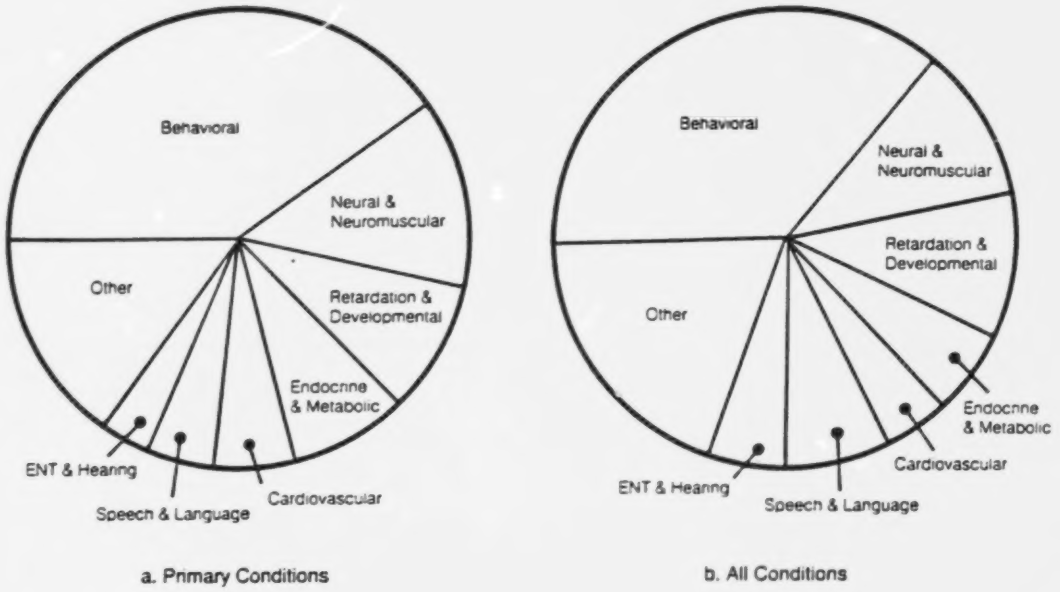
Management System

SYSTEMS PROBLEMS

- Fragmented Resources
- Fragmented Responsibilities
- Duplication of Efforts

NOTE: CHSC has cooperative arrangements with and/or participates in related programs of the State Department of Health and University of Iowa Hospitals and Clinics.

Handicapping Conditions at Integrated Evaluation and Planning Clinics



a. Primary Conditions

b. All Conditions

The largest group of children referred are for a combination of behavioral, emotional and social problems, especially hyperactivity or Attention Deficit Disorder. Children with medical problems are also a large group including a broad range of developmental delay problems, enuresis and encopresis, obesity, urinary incontinence, problems of neurological dysfunction, etc. The behavioral and school-related referrals include problems with peer relationships and a variety of social and emotional problems involving poor self-esteem, uncontrollable behavior, and other problems associated with unstable family conditions.

APPENDIX C

SYSTEM DEVELOPMENT ALTERNATIVES: STATES AND FEDERAL

SYSTEM DEVELOPMENT ALTERNATIVES

OTHER STATES AND FEDERAL

OFFICE OF RURAL HEALTH - PUBLIC HEALTH SERVICE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

To be established in the fall of 1987, to provide a national focus for rural health issues, and to complement the ongoing efforts of foundations and others in the private sector, as well as states and local communities.

Responsibilities:

"The new office will:
(1) Work with states, private associations, state hospital associations, foundations and others to act as a catalyst for focusing attention and solutions for rural hospitals.
(2) Coordinate rural health activities throughout HHS and help coordinate efforts of other federal agencies, such as the Veterans Administration and Department of Agriculture.
(3) Establish a clearinghouse for collecting and disseminating existing and emerging information, data, and resources."
(Extracted from: Public Health Service press release; June 4, 1987)

STATE OF OREGON - OFFICE OF RURAL HEALTH (ORH)

Created in 1979, as part of the State Health Planning and Development Agency (SHPDA), to coordinate statewide efforts for providing health care in rural areas; to provide technical assistance and grants to rural communities for needed health care services; and to coordinate recruitment, placement, and retention of health care professionals who are obligated to practice in medically underserved areas of the state.

Responsibilities:

(1) Coordinating statewide efforts for providing health care in rural areas;
(2) Accepting and processing applications from communities interested in developing health care delivery systems.
(3) Through the agency, applying for grants and accepting gifts and grants from other governmental or private sources for the research and development of rural health care programs and facilities.

(4) Serving as a clearinghouse for information on health care delivery systems in rural areas.
(5) Helping local boards of health care delivery systems develop ongoing funding sources.
(6) Developing enabling legislation to facilitate further development of rural health care delivery systems and to expand the duties of the office, if necessary.

STATE OF NORTH CAROLINA - OFFICE OF RURAL HEALTH SERVICES

Created in 1973 by the legislature, as an office in the Division of Facilities Services, Department of Human Resources. Its main function is developing, in coordination with local organizations and providers, primary care services in rural areas.

Responsibilities:

(1) Providing grants and technical assistance to select communities for establishment of a community health center.
(2) Assisting both physician candidates and needy communities in a physician recruitment and placement program.
(3) Serving as a liaison for the National Health Service Corps projects in the state.
(4) Coordinating communication among rural health care professionals; and hosting state and foreign delegations to demonstrate the office's operations.
(5) Providing technical assistance to small rural hospitals in financial distress.

The following page contains a list of various State Offices of Rural Health.

STATE OFFICES OF RURAL HEALTH

Robin Miller Braun
Director
Rural Health Office
Arkansas Department of Health
4815 W. Markham Street
Little Rock, AR 72201
(501)661-2375

Gino Lera
Deputy Director
Rural Health Division
Department of Health Services
714 P Street, Suite 450
Sacramento, CA 95814
(916)322-2078

James D. Bernstein
Chief
North Carolina Office of Rural
Health
437 North Harrington Street
Raleigh, NC 27605
(919)733-2040

Charles Arfero
Executive Director
New Mexico Health Resources
P.O. Box 27650
Albuquerque, NM 87125
(505)242-0633

Marsha Kilgore
Manager
Office of Rural Health
State Health Planning & Dev.
Agency
3886 Beverly St., |19
Salem, OR 97305
(503)378-4068

James A. Crouch
Director
Bureau of Rural Health
Utah Department of Health
P.O. Box 45500
Salt Lake City, UT 84145
(801)533-6135

Fred Moskol
Director
Department of Community and
Professional Development
University of Wisconsin
810 University Bay Drive
Madison, WI 53705
(608)263-6690

Andrew W. Nichols, M.D., M.P.H.
Director
Rural Health Office
Dept. of Family & Community Medicine
University of Arizona
3131 E. Second Street
Tucson, AZ 85716
(602)626-7946

J. Stephen Wright, Ph.D.
Director
Rural Health Office
Georgia Southern College
Box 8148
Statesboro, GA 30460-8148
(912)681-5144

Kevin Fichenscher, M.D.
Director
The Center for Rural Health
Services, Policy & Research
University of North Dakota
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Grand Forks, ND 58202
(701)777-3848

Dr. H. E. Crow
Director
Office of Rural Health
School of Medicine
University of Nevada
MacKay Science Bldg., Rm 201
Reno, NV 89557
(702)784-4841

Lois Barry
Executive Director
Texas Office of Rural Health
Texas Tech University
Regional Academic Health Center
400 W. 4th., Suite 243
Odessa, TX 79761
(915)335-5117

Bruce Amundson, M.D.
University of Washington
School of Medicine
Department of Family Medicine
Research Section, HQ-30
Seattle, WA 98195
(206)543-2461

Charles Huff
Director
Office of Rural & Community Health
School of Human Medicine
University of Wyoming
1522 East "A" Street
Casper, WY 82601
(307)266-3076

GRANTS-IN-AID TO CLINICS

Department of Health Services
Rural and Community Health Division
Primary Health Services Development Programs
714 P Street, Room 750
Sacramento, CA 95814

Contact Person: Sarah G. Erlach, R.N., M.P.H.
Telephone Number: (916) 324-1929

PROGRAM DESCRIPTION:

The Grants-In-Aid to Clinics program is mandated by SB 1117 (1983, formerly AB 1317/80), Health and Safety Code, Section 1187. The program is to ensure the continuation of existing clinic programs which lack financial resources and have had to curtail services. The purpose of these monies is to: (1) "stabilize health care operations of community and free clinics" which provide a wide range of primary health services; (2) fund innovative programs designed to provide high quality health services at minimum costs; and (3) maintain and restore services and staff critical to continuation of current levels of services to high-risk or underserved populations. Monies are also available for non-profit corporations (comprised of not less than three clinics in a combined service area covering one or more counties) to provide technical assistance and help defray personnel costs.

PROGRAM ACCOMPLISHMENTS:

- Currently funds 56 projects throughout the state, four of which are "associations" comprised of three or more clinics (4/5 Urban, 1/5 Rural).
- The majority of the monies are to be used for provider (physician, nurse, etc.) personnel. No monies are to be for equipment or facilities.
- It is estimated that approximately one million patient visits are provided by these funded clinics yearly.

CURRENT GOALS:

- To maintain and stabilize current operations, and to improve revenue collections to reduce dependence on state funds.

SEASONAL AGRICULTURAL & MIGRATORY WORKERS PROGRAM (SAMW)

Department of Health Services
Rural and Community Health Division
Primary Health Services Development Programs
714 P Street, Room 750
Sacramento, CA 95814

Contact Person: Sarah G. Erlach, R.N., M.P.H.
Telephone Number: (916) 324-1929

PROGRAM DESCRIPTION:

The Seasonal Agricultural & Migratory Workers (SAMW) Program is mandated by SB 1117 (1983) to maintain a program of health services for seasonal agricultural and migratory workers and their families. The program funds primary health care, encourages the development of bilingual health education, provides outreach and nutrition services, collects data on the health status and unmet needs of farmworkers, provides board training, and administers, monitors and evlauates local project operations.

PROGRAM ACCOMPLISHMENTS:

- Reestablished the program in the governor's budget of 1980-81.
- Currently fund six primary care sites and three health education.
- Originally projected to serve 10,000 Farmworkers in FY 1980-81, the program now serves over 60,000.
- In FY 1986-87 Farmworker staff took over responsibility for over 53 AB 1317 Grants-In-Aid projects.

CURRENT GOALS:

- To improve quality of care and outreach in all projects and to promote maximization of revenues.

RURAL HEALTH SERVICES DEVELOPMENT PROGRAM

Department of Health Services
Rural and Community Health Division
Primary Health Services Development Programs
714 P Street, Room 750
Sacramento, CA 95814

Contact Person: Sarah G. Erlach, R.N., M.P.H.
Telephone Number: (916) 324-1929

PROGRAM DESCRIPTION:

The Rural Health Services Development Program is mandated by SB 1117/1983 (formerly known as AB 2450/1976) to increase the amount and availability of services in rural areas of California, to improve distribution of health manpower to underserved rural areas, and to improve the coordination of services. The program has focused on providing primary health care in medically underserved areas, establishment of new health delivery systems, and utilization of and coordination with existing public health, hospital, and physicians resources. The utilization of mid-level practitioners, physician's assistants and outreach personnel from the same ethnic background as the population to be served is a key characteristic of the program.

PROGRAM ACCOMPLISHMENTS:

- Established 26 primary health centers in remote and other rural areas throughout 22 counties in the State (North Modoc-South Imperial).
- Funds three regional Health Education/Nutrition projects.

CURRENT GOALS:

- To improve self-sufficiency of projects to 50% by providing training in billing and maximizing revenues.
- Improve quality of care by promoting Quality Assurance Procedures and staff.
- Initiate computerization as a management tool.
- Simplify application process, initiate multi-year contracts.

WORKING ENVIRONMENT IN STATE OF CALIFORNIA ASSISTS RURAL HOSPITALS TO ADDRESS SPECIAL NEEDS AND CONDITIONS

Contact Person: Steve Rosenburg
Consultant, California

Telephone Number: (415) 868-0180

Rural hospitals in California are using creative management strategies to better their financial condition. Their ability to accomplish this is aided by responsive and flexible state policies and regulations that govern their working environment. California statutes have been enacted that specifically address the unique needs and conditions of rural hospitals in a rural system of health care.

The first method ("distinct part") allows hospitals to change the designation of up to 10% of their beds without CON approval. Within this classification, for example, there are three possible alternatives. The first would set aside up to 10% of the hospital's beds as short stay nursing home beds. Reimbursement for these beds is paid by Medicare under a special reimbursement plan. This 10% leeway in the certification of beds provides the hospital with much needed flexibility in its utilization of facilities in order to match needs with resources. The second alternative is to have all the beds run as regular long stay, but divide them up into acute care and skilled nursing. One possible advantage to this option is that a facility can more easily maintain full occupancy of beds. The third alternative is to mix and match various bed types--long stay acute, long stay skilled nursing and short term nursing home beds. These various combinations offer flexibility that is critical to the survival of hospitals in rural California.

The second method rural hospitals in California are using to improve their financial condition is diversification by providing non-acute care services. Here the hospital either provides itself, or contracts for the provision of such services as home care, laundry services, substance abuse clinics, meals, and housing in order to address unmet community needs. Services are tailored to filling specific gaps.

Another example of much needed flexibility given rural hospitals in California is in the range of services they are required to offer. For example, rural hospitals are not all required to have a surgery capability.

These various initiatives are representative of innovative approaches to providing quality health care in rural areas of California. Economic reality has dictated that state policymakers allow institutions some flexibility as they pursue improved and creative management strategies in providing equitable and proper health care to people in rural areas. Rural hospitals are thus able to provide more consistent, appropriate and cost-effective services.

RURAL PRIMARY CARE NETWORK AND HOSPITAL TECHNICAL ASSISTANCE THROUGH STATE OFFICE OF RURAL HEALTH

Office of Rural Health Services
North Carolina

Contact Person: Jim Bernstein, Director
Telephone Number: (919) 733-2040

A. WHY WAS PROGRAM UNDERTAKEN?

Established in 1973, the Office of Rural Health Services has helped to bring much needed primary health care services to rural communities throughout North Carolina. ORHS has helped construct 43 health centers and has recruited over 600 physicians during this time. Most recently, necessity has caused ORHS to direct its attentions to rethinking the role of rural hospitals in the rural health care system. The newly created Community Hospital Technical Assistance Program aims to do this.

B. GENERAL DESCRIPTION

A relatively independent office (no ties to Social Service or Health Service Agencies), ORHS deals directly with local communities. They employ a bottom-up approach to the problem of underserved rural areas by responding to requests from community groups for their help. Five-to-one matching capital grants are provided to communities to construct primary care clinics which serve a minimum of 750 families. In addition to financing the construction of these facilities, ORHS also provides financial assistance for operating costs during the first years of the newly formed non-profit corporation.

Management expertise is provided to these clinics via circuit riders. Although ORHS provides technical assistance and management expertise to these clinics (e.g., sets up billing systems), it does not set mandates. In today's milieu of rapid change, the need for this type of flexiblity cannot be overemphasized. A lack of mandates is consistent with the philosophy of decentralization found at the state level.

As mentioned earlier, a new development within ORHS is the Community Hospital Technical Assistance Program. This program is a direct response to the kind of change eluded to previously. At present, although it has helped some rural hospitals develop strategic planning initiatives and has provided some educational seminars for hospital administrators, this program has not had sufficient time to take shape.

C. ADMINISTRATION/MANAGEMENT

22 people work in the Office of Rural Health Services. Of these 22, ten are community organizers (circuit riders). In addition, ORHS employs two architects, two physician recruiters, one hospital technical assistance staffperson, and one quality assurance person. Some of the assistance provided by ORHS such as legal work is contracted out. Also a representative of the National Health Service Corps works out of ORHS.

D. CLINICAL

Since 1973, ORHS has helped to construct 43 health centers, and to recruit approximately 600 physicians. Again, the initial goal has been to provide primary health care facilities and personnel to rural communities that otherwise would go without these services.

E. FINANCIAL AND REIMBURSEMENT

ORHS is appropriated funds on an annual basis by the North Carolina Legislature. Last year the appropriation was approximately $1.8 million.

ORHS provides rural communities with 5 to 1 matching capital grants for the construction and initial operating costs of primary care clinics.

Physicians working in these clinics are paid an annual salary.

F. SHARED SERVICES

Linkage with social service providers varies from county to county and is based upon the relationship between those providers and the primary care providers. Once again, this is consistent with the prevailing philosophy of decentralization.

G. GENERAL INFORMATION

ORHS has taken advantage of the National Health Service Corps (a federal program) in recruiting primary care physicians. With the demise of this program next year, ORHS will have to increase its recruitment commitment if it is to attract similiar numbers of physicians to rural North Carolina.

UTAH ADDRESSES RURAL HEALTH CARE ISSUES

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A. FINANCING RURAL EMERGENCY MEDICAL SERVICE (EMS) SYSTEMS

Recently, rural localities in the state of Utah faced a dilemma not uncommon to rural areas elsewhere--how to meet the high costs of maintaining appropriate emergency medical service levels despite a limited tax base from which to finance them. Rural areas often see a large influx of people for recreational purposes. While this places an additional burden on local EMS systems, in most instances there are no mechanisms in place to offset the increased cost to the local community.

Recognizing this, the Utah Legislature passed legislation designed to take some of the burden of financing the upkeep of these systems off rural localities. A three dollar moving violation surcharge was initiated. The proceeds from this surcharge are placed in a restricted account administered by the State Department of Health. Any EMS system can then apply for funds from this account to replace or repair equipment, or train personnel.

B. KEEPING DOWN COMMUNICATIONS COSTS IN RURAL EMS SYSTEMS

The rugged terrain in rural Utah requires what are known as "mountain toppers" in order to communicate by radio. These radio communication towers can cost between $40,000 and $100,000 each to construct. Instead of spending large sums of money to set up their own network of towers, EMS systems in rural areas of the state have signed memorandums of agreement allowing them to use existing communication systems. In addition to the ambulance operators themselves, EMS coordinating staff in these rural areas are permitted in emergency situations to use the State Highway Patrol, U.S. Land Management, and U.S. Forest Service radio bands. The memorandums of agreement provide the rural EMS systems with the necessary communications network they need to function effectively without adversely affecting the financial viability of these systems.

C. ADDRESSING ELDERLY LONG TERM CARE NEEDS IN RURAL UTAH

Utah's Medicaid program has a flat rate reimbursement schedule with no allowance for capital expenses. When combined with a community-based waiver program, this encourages the expansion of residential care (under 15 units in a community) and small residential care (in home) programs. Providing a full range of services to elderly persons meeting the eligibility requirements, these programs operate at a substantially reduced cost when compared to traditional long term care facilities.

In an effort to ensure that these community-based programs meet stringent safety requirements, the state has required them to be life-safety-certified. An interface between Medicaid and life-safety-codes inspection represents an effective and less costly way of ensuring compliance than if done separately. Consequently, the Office of Special Services in the Department of Social Services oversees both programs.

KENTUCKY PHYSICIAN PLACEMENT SERVICE (KPPS)

The Kentucky Physician Placement Service (KPPS), is a division of the State Department for Health Services, established in 1982. The service matches physicians wanting to locate in a rural area with communities needing a doctor. KPPS has placed more than 150 physicians in those Kentucky counties that either the federal or state government has declared as in need of physicians. Of Kentucky's 120 counties, 50 counties or parts of counties are still designated as Health Manpower Shortage Areas by the federal government.

"We have a maldistribution of physicians in this state - as do many other states," said Doug Bishop, former director of the service. "Forty-seven percent of all Kentucky primary care physicians are in the large urban areas of Louisville and Lexington, although those cities contain only 24 percent of the population."

In addition to placing "private" physicians who want to practice in a rural area, KPPS contracts with the National Health Service Corps (NHSC) to also place its physicians. NHSC finances two to four years of medical school for students who, in turn, agree to serve an equal amount of time in a medically underserved area. Even though NHSC physicians are free to leave after fulfilling their service obligation, in Kentucky about 60 percent stay at least one year beyond their commitment, according to a study conducted by Bishop's office.

UNIVERSITY ASSISTS RURAL COMMUNITIES WITH PHYSICIAN RECRUITMENT

Southern Illinois University
School of Medicine
Financial Aid and Alumni Placement

Contact Person: John Record, Asst. Dean
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Southern Illinois University's School of Medicine assists rural Illinois communities in physician recruitment in several ways. This assistance started in 1978 when the Illinois Department of Agriculture provided the University with a three year grant specifically for this purpose. Nine years later, the initiatives encouraged by this grant are still serving rural Illinois communities.

One way the University assists rural communities in physician recruitment is by publishing an annual booklet which describes practice opportunities throughout the state. Localities wishing to be included in the booklet send the University information and pictures describing life in their particular community. Using this material, the University designs a one-page spread highlighting what each community has to offer physicians who would practice there.

A second publication offered by the University is a directory of communities which are actively recruiting physicians. This directory is published on a biannual basis. Both of these publications are sent to all the medical schools in Illinois, as well as to primary care programs in contiguous states.

A third way in which the University assists rural communities is by sponsoring an annual Doctor's Fair. Drawing an average of 45 to 55 exhibitors each year, the fair provides a chance for initial, face-to-face contact between communities seeking to attract physicians and residents and doctors looking for placement.

The training of more and more American physicians was expected to lead to a diffusion of these doctors into rural communities. At present, however, this diffusion is not occurring as anticipated. Thus, there continues to be a need for this type of physician recruitment assistance.

COORDINATION OF TITLE 20 AND MEDICAID IN MAINE

Bureau of Medical Services
Maine

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Coordination of the Title 20 program and the Medicaid program in Maine allows for the provision of not only a greater range of services, but also for greater flexibility in providing the most appropriate level of services. Coordination is achieved through a case management approach at the local level.

The coordination of the two programs occurs at the Area Agencies formed under the Older Americans Act. Here case managers complete forms and send them to the Bureau of Medical Services where a determination is made as to an elderly person's eligibility for a Medicaid waiver for homemaker care. The criteria are nursing home eligibility and financial eligibility. The funding for this type of waiver is capped.

If the person is not eligible for the Medicaid waiver for homemaker care, or if the funding is exhausted, then Title 20 monies can be accessed. The Bureau of Social Services contracts with private non-profit agencies for the provision of services. Such services include daycare for the elderly, transportation, nutrition, and homemaker care. Title 20 funding is provided on a priority basis. Child protected and adult protected categories are the highest priorities, but "elderly at risk of being placed in a nursing home" is another high priority.

By determining, case to case, which funding source to access, the case managers can make the best use of existing monies while providing appropriate levels of care.

SEPARATE AGENCIES ADMINISTER MEDICAID

Senior Service Division
Oregon

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The administration of Medicaid in Oregon has been split into two separate agencies. Medicaid for acute care patients is administered by the Welfare Division, while Medicaid for elderly long term care patients is administered by the Senior Service Division. The strength of splitting medicaid in this way is evidenced by an increased ability to serve more of the elderly population, as well as by the estimated savings of $15,000,000 since the program's inception in October of 1981.

Eighteen area agencies formed under the Older Americans Act exist in Oregon. If they meet certain requirements they are permitted to administer Medicaid, the Older Americans Act program, and the State-funded homemaker program. Eleven of the eighteen have met these requirements, while the other seven administer only the Older Americans Act program. (A similiar situation now exists in California where long term care programs are administered locally by Area Offices for the Aging).

Permitting more flexibility, this split has shifted the emphasis from placing eligible elderly persons in nursing homes to less traditional methods of care. In home and adult foster care rates have more than doubled since the split, while the number of elderly residing in nursing homes has decreased by ten percent. These trends account for the savings realized since the program's inception.

ILLINOIS HEALTH FACILITY AUTHORITY SERVES SMALL, RURAL FACILITIES AS WELL AS LARGER, URBAN FACILITIES

Illinois Health Facility Authority
Illinois

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Formed to provide less expensive public financing to health facilities in Illinois, the HFA caters to small as well as large facilities, and to rural as well as urban facilities. An important undertaking by HFA in this regard is informing small rural facilities of its existence, for their benefit as well as for the benefit of larger facilities located in metropolitan areas of the state.

In addition to making sure that all health facilities, regardless of size or location, are informed of their ability to issue tax exempt debt through it, the HFA also has programs that are designed to meet the special needs of smaller, rural facilities. One example is the "pooled loan program." By encouraging smaller facilities to borrow simultaneously this program allows them to borrow relatively insignificant amounts, such as one million dollars, for capital improvement and still permits them to take advantage of the better terms available to larger borrowers.

LEGISLATION FROM OTHER STATES

The following laws are examples of how other states are attempting to solve problems facing health care. They are organized according to category with 1985 legislation preceding bills passed in 1986.

Rural Health

1986 Florida Laws, Chap. 86-200 (HB 1313) requires the Department of Health and Rehabilitative Services to provide a statewide prenatal care program for low-income pregnant women and to monitor the availability and accessibility of prenatal care services and the development of special outreach programs for medically underserved and rural areas.

1986 Kansas Sess. Laws, Chap. 357 (SB 621) requires recipients of medical school scholarships to agree to enter an approved three-year primary care residency program; to practice medicine for a period of one year for each year of scholarship assistance in a city of less than 12,000 population and not located in specified counties; and to repay all moneys, with interest, if they do not meet the conditions. The act also transfers the responsibility for designating medically underserved areas from the secretary of health and environment to the chancellor of the University of Kansas; creates the Medical Scholarship Advisory Committee, and authorizes the chancellor to appoint a medical scholarship program coordinator to plan and administer the provisions of the act.

Certificate of Need

1985 New Hampshire Laws, Chap. 378 adds as a standard for certificate of need approval the degree to which the proposed expansion or new institutional health service will be accessible to persons who traditionally are medically underserved.

1985 Maryland Laws, Chap. 107 repeals the requirement for CON approval of major medical equipment and directs the Secretary of Health and Mental Hygiene to establish a licensure program for hospitals' and private physicians' office equipment. Authorizes a licensing fee to defray costs of licensure review. Exempts biomedical research equipment if no patient or third-party payor will be charged for its use. Exempts health maintenance organizations from licensing requirements. The program is scheduled to sunset in two years.

1985 Maryland Laws, Chap. 109 allows hospitals to close, downsize, merge, or consolidate their facilities without CON approval.

1985 North Carolina Sess. Laws, Chap. 74 raises the threshold for CON review and approval of capital expenditures from $600,000 a year to $1 million a year, and major medical equipment from $400,000 to $600,000. Clinical laboratory equipment is no longer exempt from CON review, but freestanding outpatient facilities are exempt. CON review is now required for all equipment, including previously exempt physician-owned equipment.

1985 Oregon Laws, Chap. 747 changes certificate of need law, increasing the threshold for hospitals' capital expenditures on a formulated percentage basis. The threshold for purchases of major medical equipment is increased to $1 million. This law brings all buyers of major medical equipment under CON review, even if they are situated outside a hospital. It also adds freestanding birthing centers to the list of facilities covered by CON review, except for "low volume" centers and those that had begun operating prior to July 1. The bill allows hospitals that receive 60 percent or more of their inpatient revenues on a capitated basis, either under prospective payment or prepaid health maintenance organizations, to apply for a waiver of CON review.

1986 Iowa Acts, chapter 1150 (SF 2207) establishes a two-year exclusion from CON requirements for residential care facilities. The Department of Public Health is required to monitor the exclusion and make recommendations to the governor and the General Assembly regarding the continuation of the exclusion.

1986 New Jersey Laws, Chap. 11 (A 643) provides for the establishment of respite care programs in hospitals without CON approval if the hospitals have an average weekend vacancy rate of 20 percent or more over a six-month period.

1986 Oklahoma Sess. Laws, Chap. 149 (HB 1893) increases the review threshold for capital expenditures from $600,000 to $5 million over a three year period; increases the review threshold for the initial acquisition of major medical equipment from $400,000 to $3 million; increases the review threshold for longterm care services from $150,000 to $500,000 for any capital investment or lease; specifies requirements for CON review of long-term care facility construction; allows facilities to convert up to 10 beds to swing bed status without CON review if they qualify under Medicare guidelines; and places a statutory time limit for CON review. The act also abolishes the State Health Coordinating Council, replacing it with a State Health Planning Advisory Board, and requires that a State Health Plan be developed and published once every four years.

1986 Tennessee Pub. Acts, Chap. 879 (HB 1838) requires CON applications for inpatient psychiatric facilities for children and adolescents to contain certification that 40 percent of the annual inpatient days will be allocated to children and adolescents who are Medicaid recipients or medically indigent.

Health Facility Regulations

1985 Maine Laws, Chap. 189 exempts municipal agencies which provide non-acute preventive health care and health education to clients in the home from the licensing requirements for home health care agencies.

1986 Kansas Sess. Laws, Chap. 390 (HB 3124) allows hospital districts that terminate the operation of a district hospital to become a health care facilities and services hospital district and to continue to operate a clinic, long-term care facility, home for the aged, or emergency medical service.

1986 Massachusetts Acts, Chap. 324 (S 1984) requires licensure for clinical laboratories that are not part of a licensed hospital or clinic, with exceptions for labs maintained by up to three physicians using it to diagnose their own patients (and which meet other criteria); labs maintained exclusively for research and teaching purposes; and labs that conduct tests for certain insurance purposes.

Health Maintenance Organizations (HMOs)

1985 North Carolina Sess. Laws, Chap. 58 allows HMOs in bordering states with a similar reciprocity law to do business in the state.

1985 North Carolina Sess. Laws, Chap. 666 requires all HMOs taking advantage of state reciprocity provision to be federally qualified and comply with all HMO requirements in the state.

1986 Ohio Laws, S. 325 establishes the Medicaid Health Maintenance Organization Oversight Committee to monitor the growth development of HMOs and alternative health care delivery systems providing services to Medicaid recipients; and requires the committee to study specified issues, including whether to initiate a mandatory enrollment plan for Medicaid recipients, and to report to the General Assembly and the Departments of Human Services and Insurance by June 10, 1988.

Reimbursement

1985 Nevada Stats., Chap. 469 requires health insurance policies to provide for the reimbursement of services provided by registered nurses in advanced practice if those services are reimbursed when provided by another health care provider.

1985 New Hampshire Laws, Chap. 239 requires insurance providers to reimburse for any service that may legally be performed by an advanced registered nurse practioner.

Mandated Benefits

1985 New Jersey Laws, Chap. 274-277 require Blue Shield/Blue Cross/commercial individual health insurers/commercial group health insurers to offer coverage for expenses of pregnancy and childbirth without regard to marital status.

1986 Arizizona Sess. Laws, Chap. 352 (HB 2473) extends maternity benefits of an adopting parent under an insurance contract or policy to include care of the natural mother prior to and including the birth of the child if the child is adopted within one year of birth, the insured is legally obligated to pay the cost of birth, and all existing conditions of the contract have been met by the insured.

1986 Tennessee Pub. Acts, Chap. 773 (SB 1875) specifies that coverage for dependent children be extended to age 24 for those who are unmarried and dependent upon the insurer for support and maintenance.

1986 Florida Laws, Chap. 86-40 (HB 170) requires any health insurance policy, health care services plan, or other contract providing for the payment for medical expense benefits or procedures to be construed to include payment to a chiropractic physician who provides benefits or procedure that are within the scope of a chiropractic physician's license. (Note: This law resulted from a veto override of HB 170 of the 1985 Regular Session.)

Other Insurance Regulations

1985 Wisconsin Act 29, Stat. Chap. 609 allows small, independent health care providers to form joint ventures in order to effectively compete with preferred provider organizations, health maintenance organizations, and limited service health organizations.

Hospitals

1985 Maryland Laws, Chap. 109 establishes incentives for hospitals to voluntarily reduce the number of hospital beds through: exemption from certificate of need approval for hospitals wishing to close, downsize, merge, or consolidate; rate adjustments in accordance with the downsizing of the facility; exemption from anti-trust laws in cases of mergers, consolidations or joint ownership of major medical equipment; and programs to assist closing hospitals in covering bonded indebtedness and retraining displaced hospital employees.

1985 Minnesota Laws, First Spec. Sess. Chap. 14 establishes a health care equipment loan program to aid hospitals in purchasing medical equipment.

1985 Maryland Laws, Chap. 549; 109 establishes the Maryland Hospital Bond Program to refinance public bonds for hospitals that close or are delicensed, and the Hospital Employees Retraining Program for workers displaced by closure, delicensure, or merger. The programs will be financed by a fee assessed against currently operating hospitals.

1986 Louisiana Act, P.A. 899 (H1958) relates to regulation for licensing of hospitals and provides standards for any health care facility proposing to utilize beds for extended care and admit Medicaid nursing home patients.

1986 New Jersey Laws, Chap. 11 (A 643) appropriates $50,000 to establish hospital respite care programs to provide care for elderly persons while enabling those who care for them to be temporarily relieved. To qualify, hospitals must have overall vacancies of 20 percent or more during the prior six months. A certificate of need is not required for the programs, but rates for the service are subject to the approval of the Hospital Rate Setting Commission.

Medicaid

1986 Kentucky Acts, Chap. 154 (H 78) requires skilled nursing facilities or intermediate care facilities participating in Medicaid to agree to serve at least as many Medicaid recipients as the statewide average; and prohibits long-term care facilities participating in the Kentucky Medical Assistance Program from denying admission to a Medicaid bed based on the patient's paying status.

1986 Mississippi Laws, Chap. 437 (SB 2116) makes essential transportation services reimbursable under the Medicaid program.

Medically Indigent

1985 Oklahoma Sess. Laws, Title 56 provides for an income tax check-off to provide funding for indigent health care. The monies received from the program shall be deposited in the "Indigent Health Care Revolving Fund" to be used to implement the provisions of the Oklahoma Indigent Health Care Act.

1985 South Carolina Acts, Act 201 creates the South Carolina Medically Indigent Assistance Fund financed by equal contributions from county and general hospital assessments. Funds will be used solely to compensate general hospitals for providing medical care to the medically indigent. County contributions will be assessed by a formula based on property value, per capita income, net taxable sales, and consideration of previous years claims. Contributions to counties from the fund must be credited against the county assessment.

1985 Texas Gen. Laws, Chap. 1 the Indigent Health Care and Treatment Act, requires counties to provide the following health care services to persons who meet the basic income and resource requirements for Aid for Families with Dependent Children but who are categorically ineligible: hospital services; rural health clinic servies; lab and x-ray services; family planning; physician services; a maximum of three prescription drugs per month; and limited skilled nursing facility services. Counties may require eligible persons to see only specified providers and pre-authorize any service for non-emergency care. Counties are not liable for services to a person who resides within an area served by a public hospital or hospital district that has a legal obligation to deliver care to the medically indigent. Public hospitals and hospital districts are subject to similar indigent care rules. Maximum payment rates are the same as those for the Medicaid program. Counties are liable for each recipient to a maximum payment of $30,000, or to a total of 30 days of hospitalization or treatment in a skilled nursing facility--whichever occurs first in one fiscal year. State assistance is available to those counties that expend at least 10 percent of their general revenue levy to provide mandatory health care services. The state will pay 80 percent of actual payments after the 10 percent expenditure level has been reached. The act also creates an Indigent Health Care assistance fund to pay the state portion of indigent care costs and to pay for other indigent care programs, e.g., social security program for children, and prenatal services for low income individuals. $22 million has been appropriated from the fund for FY 1986 and $41 million for FY 1987.

1986 Arizona Sess. Laws, Chap. 89 (SB 1248) allows county boards of supervisors, with the approval of the Department of Health Services, to contract for the provision of health services publicly funded by the Department of Health Services; and requires counties to reimburse licensed physicians for emergency services provided to county indigents in a hospital.

1986 Iowa Acts, Chap. 1250 (HF 2484) establishes an indigent obstetrical patient quota for delivery at the University of Iowa Hospitals and Clinics and reallocates $1.1 million of the state appropriation to counties for obstetrical services to eligible persons.

1986 Utah Laws, Chap. 179 (SB 207) gives immunity to providers of products or services for indigents from any suit for unintentional damages arising from the use of products or services.

Emergency Medical Services

1985 Virginia Acts, Chap. 333 provides that the 25 percent of the " one-for-life" component of motor vehicle registration fees returned to localities may be used to provide funding for the training of salaried or volunteer emergency medical service personnel, licensed, non-profit emergency medical service agencies, and for purchase of equipment and supplies for use by licensed, non-profit emergency medical and rescue services.

1986 California Stats., Chap. 1162 (SB 1791) expands the definition of hospital under the Emergency Medical Services System and Prehopsital Emergency Care Personnel act to include licensed out-of-state hospitals that substantially meet California licensing requirements. The act also allows a rural EMS agency, with approval of the state EMS Authority, to use hospitals not having a basic emergency medical service to give direction to and receive patients from prehospital emergency medical care personnel.

1986 Delaware Laws, Chap. 397 (S 199) allows a personal income tax credit for members of Delaware volunteer ambulance and rescue services.

1986 Florida Laws, Chap. 86-220 (HB 1313) deregulates nonemergency medical transportation services or transport services for persons who are confined to a wheelchair or a stretcher; authorizes the provision of prehospital emergency medical care by EMTs and others to minors without parental consent; and increases from five to 15 percent the amount of money in the EMS Trust Fund that can be used for administrative purposes to allow EMS regulation to be self-supporting.

1986 Louisiana Acts, P.A. 630 (SB 494) clarifies the scope of permissible functions of an EMT-intermediate and an EMT-paramedic and adds permissible functions of an EMT-basic; adds authority for an EMT-intermediate to perform the functions of an EMT-paramedic, but only during training for certification at the paramedic level and while under the direct supervision of specified personnel; and permits certain life-saving service by certified EMT-intermediates and EMT-paramedics when voice contact with a physician cannot be established.

Excerpted from: *1986 Health Care Legislation* (National Conference of State Legislatures)

APPENDIX D

SYSTEM DELIVERY ALTERNATIVES IN NEW YORK STATE

SYSTEM DELIVERY ALTERNATIVES

NEW YORK STATE

SHARED SERVICES

Southern Tier Area - Increasing Access to Medical Specialists

In July 1986, a ten-physician group in Corning (Steuben County) merged with a Sayre, Pennsylvania medical group, located about 40 miles away. This new cooperative arrangement was made as a response to the challenges facing small rural hospitals as well as individual practicing physicians, particularly problems associated with recruiting physicians and with new federal and state reimbursement systems. As a result of the medical groups' merger, the Corning area, currently served by only one obstetrician, has two additional physicians practicing obstetrics and gynecology. Also, an associate in internal medicine and one in gastroenterology have relocated to Corning. The Corning Hospital remains an independent acute care facility.

Catskill and Leatherstocking Areas - Increasing Access to Medical Personnel

Bassett Hospital has ten satellite health centers. The satellites are either operated by Bassett directly of are community-operated with Bassett providing the nurses and doctors. The ten centers, (which had about 175,000 outpatient visits in 1986), are staffed by both a physician and a nurse practitioner, or in some cases, a nurse practitioner alone. In either case, physicians make regular visits to the health centers, and the nurse practitioners can consult directly with the hospital's full staff of physicians.

North Country Area - Cooperation Between Secondary and Tertiary Hospitals

In July 1986, Canton-Potsdam Hospital signed an agreement to affiliate with Burlington's Medical Center Hospital of Vermont, a 470-bed teaching hospital. While Canton-Potsdam remains a separate, independent organization, its officials felt that increased cooperation between the two facilities would lead to the highest quality of care possible in the region. Specifically, the affiliation includes a formal referral arrangement for procedures that cannot be provided at Canton-Potsdam by MCHV physicians, and assistance for Canton-Potsdam in the areas of physician recruitment and continuing medical education programs. MCHV also has an agreement with Moses-Ludington Hospital in Ticonderoga (Essex County). The Vermont hospital provides consulting services to Moses-Ludington in the areas of finance, marketing, and public relations; the agreement was cited as a big factor in the Health Department's favorable view of Moses-Ludington.

Finger Lakes Area - Hospitals Studying a Possible Merger

The Finger Lakes Area Hospitals' Corporation (FLAHC) began a study in October 1986 to investigate the idea of consolidating all six of its member hospitals under a single corporate umbrella. Some reasons for thinking of merging: better access to capital financing, easier physician recruitment, and the possibility that the Department of Health would take the recommendations of a six-hospital entity more seriously than the suggestions of a single samll entity. FLAHC's members are: F.F. Thompson in Canandaigua, Newark-Wayne in Newark, Soldiers and Sailors in Penn Yan, Myers Community in Sodus, Taylor Brown in Waterloo, and Geneva General in Geneva.

IMPROVED TRANSPORTATION AND COMMUNICATIONS SYSTEMS

Air Transport

Chautauqua County has a medical-emergency helicopter which is available to all hospitals in the county. The helicopter was jointly purchased by the county and the WCA Hospital. Similarly, a medical-emergency helicopter working out of the Rochester-Monroe County Airport serves an area which includes Allegany, Chemung, Schuyler, Seneca, Yates, Steuben, Wyoming, Genesee, Wayne, Ontario, Livingston, and Monroe counties.

Lifeline Programs

Lifeline Programs are increasing in New York State. Lifeline is a personal emergency response system whereby older and/or disabled people wear an electronic device that is capable of immediately contacting a hospital in case of emergency. Canton-Potsdam Hospital, for example, started with four subscribers in 1984 and now has 35.

Mobile Cat-Scan

Mediq Mobile Service has a Mobile Cat-Scan, which serves three rural hospitals in Lewis, Jefferson, and Oswego counties, providing all of the testing services of permanent CT scanners in larger metropolitan hospitals. A truck pulls up to a hospital exit which has been specially fitted to allow the mobile unit to temporarily become a part of the facility. The truck currently contracts with Lewis County General Hospital for two half-days per week, in addition to spending three full days at Oswego Hospital and three half-days at Mercy Hospital in Watertown. Benefits of this arrangement include reduced hospital costs, access to services regardless of road and/or weather conditions, and reduced wear and tear on the local ambulance services. (Lewis County Search and Rescue estimates that the visiting scanner will reduce ambulance transfers to Watertown by 125 to 150 runs per year.)

Minibuses

Some rural communities have purchased minibuses which make scheduled trips to medical centers. Margaretville Memorial Hospital Auxiliary raised funds to purchase a transportation van equipped with a wheelchair lift. Auxiliary members volunteer to drive the van and assist individuals with their visits to the hospitals and/or doctor's office. Moreover, Madison County has put health care professionals and social services representatives on the road in a mobile health clinic in order to reach more remote residents. Although the program is still in the test stage, it is working and will be expanded. The majority of users, so far, have been the elderly, some of whom had not seen a doctor in several years.

Volunteer Transportation Services

Many local agencies operate volunteer transportation services for specific client populations. For example, many area Offices for the Aging offer transportation services for elderly persons for medical appointments and to nutrition sites, as well as for shopping and other personal errands. The services are generally provided by volunteers in their own private vehicles, who are reimbursed for mileage, and the area OFA usually maintains a liability insurance policy sufficient to augment each individual driver's vehicle liability policy.

HEALTH EDUCATION PROGRAMS

Planned Approach to Community Health (PATCH)

In rural towns of Albany and Greene counties a program called Planned Approach to Community Health (PATCH) was designed to strengthen the collective capacity of communities to deliver health education and promotion programs in their areas. The PATCH program receives funding from the U.S. Center for Disease Control, the NYS Department of Health, and the Rensselaerville Institute. After the major health problems were ranked and prioritized by conducting a telephone survey of 800 households of the affected rural areas, health education programs were planned and implemented at local sites. Classes include smoking cessation, weight control support groups, an exercise video-tape program, a stress reduction and relaxation workshop, a class in belly dancing, and new programs designed specifically for the elderly, such as Altzheimers support groups, respite care programs, exercise classes for elderly persons, and information hotlines. PATCH also publishes a newsletter which has brief descriptions of the programs available and also other services such as Local Library Health Promotion Centers, and Free Blood Screening Clinics. The first session of the PATCH program, held last spring, reportedly attracted over 500 residents from the rural communities.

Medical Bookmobile Program

Rochester General Hospital's medical library runs a medical bookmobile program serving eight small hospitals in a five-county area (Wyoming, Livingston, Ontario, Seneca, and Wayne). The program was begun in 1982; it receives some state funding, and the member hospitals pay the remainder of costs by subscribing to the service. A "circuit librarian" travels throughout the region carrying materials requested by physicians and other health care professionals from the base hospital.

COORDINATED HEALTH SERVICES

Essex County's Coordinated Care Unit

In Essex County, the Office for the Aging, the Department of Social Services, Public Health Nursing Service and the Mental Health Department along with Mountain Valley Home Services, formed a Coordinated Care Unit. Teams consisting of a social worker and a public health nurse visit people in need of home health care and help them decide what services they need, including transportation and "meals on wheels." The unit also has a hospital liaison who works with the area hospital to make sure that home care needs of newly discharged patients are met.

North Country Area - Coordinating Long Term Care

A new Community Alternative Systems Agency (CASA) in St. Lawrence County was devised by the county's Long Term Care Coordinator in February 1987, to set up a system to enable one county employee to find the appropriate help for any person with long term health or mental health problems. A 24-hour telephone hotline and intake system is now in service, with a staff member trained to take calls and to determine which county agency, public corporation, or private organization can best fill the caller's needs, and then assign someone to actually go out and meet the caller.

SARATOGA COUNTY - COORDINATION OF HOME HEALTH CARE SERVICE DELIVERY

As the demand for and acceptance of long-term home health care continues to increase, complications innevitably will arise among the growing numbers of home care providers. Saratoga County is an upstate New York county with a semi-urban population in the southern portion and a sparse rural population in the northern section. The county's Public Health Nursing Service (which previously had been the sole provider), became concerned when a number of new not-for-profit nursing agencies requested State Health Department approval to operate in the county. The county agency was worried that the not-for-profit and privately operated services would go after the profitable home care cases and leave the charity cases for the county, especially with the decreasing level of reimbursement from Medicaid for indigent patients. This would leave the county public health nursing service with a disproportionate share of available income to support its programs.

The county nursing agency, which has been expanding its own home health services, has asked the state Department of Health to designate them as the lead agency responsible for assigning patients to home care agencies in an equitable manner. This will ensure that all patients have equal access to home health care and will simplify the process for needy patients who can go to one agency and receive the information they need. In addition, this will enable the county to continue monitoring home health care and will prevent private agencies from aggressively soliciting the higher income services, to the exclusion of other less profitable case loads. Moreover, it is believed that through coordinated case management as proposed, a rational assignment or sharing of scarce home health aide personnel will occur. Ultimately this will benefit the patient, the provider and home health personnel.

The private, not-for-profits were initially upset at the county's proposal but have since agreed in principle to work cooperatively with the county. The Saratoga county nursing agency is waiting for approval from the state Health Commissioner.

NORTHERN DUTCHESS HOSPITAL'S SATELLITE CLINIC ADDRESSES THE HEALTH CARE NEEDS OF A RURAL, MEDICALLY UNDERSERVED AREA

Satellite clinic of Northern Dutchess Hospital
Stamfordville, N.Y.

Contact Person: Michael Mazzarella
Telephone Number: (914) 876-3001

A. WHY WAS THE PROGRAM UNDERTAKEN?

The clinic, located in Stamfordville, N.Y., was constructed to meet the needs of a medically underserved area.

B. GENERAL DESCRIPTION

The clinic is located in a rural area. The nearest hospital, Northern Dutchess, is twelve miles away. The per capita income is low and there is a large number of Medicaid recipients in the area. The clinic was constructed with local assistance and has been in operation since 1979. It serves 3,400-4,000 people annually.

C. ADMINISTRATION/MANAGEMENT

The clinic is staffed with one full-time physician's assistant and a nurse. The clinic was originally intended to be staffed with a full-time physician; however, efforts to procure a doctor were unsuccessful. Presently, the supervisory physician from Northern Dutchess Hospital goes to the clinic every Friday.

D. CLINICAL

The clinic concentrates on primary care. It is an adjunct to the Northern Dutchess Hospital Emergency Room with the emergency room physicians providing technical support to the clinic.

E. FINANCIAL AND REIMBURSEMENT

The clinic, as it serves a large percentage of medically indigent clients, has very low fees. An office visit costs $18.00. The clinic usually runs on a deficit. For the month of January its operating cost was $6,800 with a loss of $2,000. In 1986 the clinic lost $15,580 and had an operating cost of $85,000. Northern Dutchess Hospital picks up the deficit incurred by the clinic.

F. SHARED SERVICES/LINKS

Shared services include the visiting physician on Fridays and the link to the Northern Dutchess Hospital Emergency Room. In addition, referrals are integrated in the out-patient resources of the hospital, i.e., lab, Xray, EKG, etc.

G. GENERAL INFORMATION

The clinic, according to Mr. Mazzarella, has been a great success. It meets the community's primary care needs. The community is also crazy about it which Mr. Mazzarella feels is primarily due to the exceptional qualities of the Physician's Assistant. The only improvement Mr. Mazzarella would like to see would be the elimination of the deficit.

DUTCHESS COUNTY COMMUNITY ACTION AGENCY ADDRESSES THE NEEDS OF SENIOR CITIZENS AND THEIR CAREGIVERS

Dutchess County Community Action Agency DCCEO
Millbrook, N.Y.

Contact Person: Marilyn Pletzer
Telephone Number: (914) 876-3001

A. WHY WAS THE PROGRAM UNDERTAKEN?

Community Action Agencies identify the needs and/or gaps in services in a community. One gap and need that was seen in Dutchess County was a service that would assist caregivers of older adults disabled with Altzheimers and Dementia. Caregivers, who are normally family members, usually want to keep their relatives at home; however, they are often overwhelmed with the amount of care involved. Moreover, the shortage of long term care facilities also necessitates alternate methods of care for older adults as well as some respite for their caregivers.

B. GENERAL DESCRIPTION

The Special Day Care for the Elderly Program is a Social/Recreational Program. Presently there are two adult care centers; one is in Millbrook, New York and has the capacity to serve twelve persons. The other center, which just opened in August of 1986, is in Redhook, New York and has the ability to serve fifteen persons. Both centers were originally intended to serve only elderly people; however, the age group has expanded and currently they provide care for persons ranging in age from 25-92. The program operates 5 days a week with an average participation of 3 1/2 days. It is described as a basic social/recreational program with individual orientation. Exercise is always included along with a hot meal and two snacks.

C. ADMINISTRATION/MANAGEMENT

The Community Action Agency administers both programs. Staffing includes a Site Manager, an Activities Coordinator, and an Activities Aid. They also have many volunteers, seven who are very active. The volunteers are usually not related to the clients and they are a mixed group in terms of age.

D. CLINICAL

As the programs are socially oriented there are no clinical services offered and the programs are linked to a variety of clinical services.

E. FINANCIAL AND REIMBURSEMENT

One-third of the clients are eligible for financial assistance under the Long Term Health Care Program and Medicaid which pays $25.00 per day for the service. If a person is not eligible for this funding his or her fee is $10.00 to $50.00 per day; however, the average charge is usually $20.00. Funding for the first program in Millbrook was attained through two private donations of $30,000. The Millbrook program's total expenses last year amounted to $57,000. Sixty perent of this cost was covered by revenues generated by the daily charge. The program in Redhook, which started in August of 1986, began with a $15,000.00 grant from United Way and private donations. So far it has generated 14% of its expenses through the fees charged. It is hoped that eventually both programs will be self-supporting.

F. SHARED SERVICES/LINKS

Because the needs of their clients often extend beyond social and recreational activities, the Community Action Agency draws upon the existing professional services from the Public Health and Mental Health Departments. Transportation to the program is designed for the families to provide. If a person is eligible for L.T.C., that program will pay for the transportation costs incurred and the CAP agency will provide the service. If there is a person who is not eligible for L.T.C. and has no transportation, the CAP agency will also transport him/her as long as the cost to him/her is minimal (less than $10.00). If it exceeds this cost the CAP agency will work with the person to find another mode of transport. The CAP Agency also helps the family with the procedures involved in obtaining assistance in the home, such as a home care worker.

G. GENERAL INFORMATION

The strength of this program, as seen by Marilyn Pletzer, is that it provides an affordable support service for families not able to cope alone with an aged or handicapped adult, prior to Long Term Care. The program helps to modify behavior as witnessed by one aging couple with a mentally handicapped adult child. The care she demands at home is much less now that she is attending the program. It provides her with activities and with something to look forward to doing. It also helps career families, as the hours of the program extend from 7:00 a.m. to 5:30 p.m. Moreover, the program involves many other members of the community, as joint functions are done with Head Start and with the local High School. Ms. Pletzer also reported that she has met with four other agencies/communities interested in starting their own program in Dutchess County (Poughkeepsie), as well as in Orange, Sullivan, and Ulster Counties.

Description of Portable Dental Clinic Demonstration Project

The Cap agency has witnessed an overwhelming need for dental services in Dutchess County for the elderly and for the medically indigent. In Dutchess County there are only six dentists who accept Medicaid. This practice costs the state money, as many times a person on Medicaid will not see a dentist until it is an emergency situation. Emergency care costs $50.00 to $60.00 more than primary care. Moreover, the elderly in Nursing Homes have difficulties in receiving care as oftentimes the home is not accessible. The proposed portable dental clinic is unique as it will be able to be utilized in any environment. The CAP agency is hoping to receive monies from the United Way, the N.Y.S. Health Department, the N.Y.S. Legislature and from private funding. The dentists will be contracted with the CAP agency.

FULTON COUNTY CENTRAL ASSESSMENT PROGRAM

Contact Person:
Mary Ellen Dowling
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Northeastern New York
(518) 452-3300

A. WHY WAS THE PROGRAM UNDERTAKEN?

To assist frail elderly and their families make appropriate choices regarding institutional or in-home care so as to simplify entry to the long term care system, maximize client choice and minimize personal and public expenditures.

B. GENERAL DESCRIPTION (including components, service area and clients)

The major component is the creation of a single, easily identified county government program for the assessment, placement and case management of all Fulton County elderly in need of long term institutonal or in-home health and/or social support services.

C. ADMINISTRATION/MANAGEMENT (including organization, staffing, functions)

The unit is located physically in the County Public Health Nursing Service funded through the Department of Social Service Medicaid Program and staffed by shared personnel from the county's Public Health Nursing Service, Department of Social Services and Office for the Aging. Supervision is provided by a Central Assessment Program Coordinator.

D. CLINICAL

A team comprised of a caseworker and a public health nurse assesses the social and medical needs of each client referred and prepare a care plan.

E. FINANCIAL AND REIMBURSEMENT

The major source of reimbursement is the Medical Assistance Program, a county administered program heavily reimbursed by the federal and state governments. Shared staff are also funded through the New York State Community Services for the Elderly Program.

F. SHARED SERVICES/LINKS

Shared staff from three county agencies perform the assessment and case management function and make referrals to other service providers as appropriate. A Council on Long Term Care, comprised of representatives from local health and social services agencies as well as consumers of service, provides overall program direction.

G. GENERAL INFORMATION (overall assessment including results, strengths/successes, weaknesses/problems in the system)

A full evaluation of the program is currently underway. A preliminary review indicates a high success rate in serving and appropriately placing clients. A need exists for still further coordination and communication, for additional in-home services, particularly para-professional aide and homemaker services, and for such community-based services as adult day care and respite for families.

AT-HOME CARE, INC.

Contact Person:
Joan Frering
Health Systems Agency of
Northeastern New York
(518) 452-3300

A. WHY WAS THE PROGRAM UNDERTAKEN?

To provide a coordianted structure for a viable home health care delivery system in rural areas.

B. GENERAL DESCRIPTION (including components, service area and clients)

Coordinated effort to develop a Certified Home Health Agency with participation of all hospitals in Herkimer, Delaware and Otsego Counties and a Home Health Aide Agency (Catholic Charities). Service areas would include entire Counties (Herkimer, Delaware, Otsego) with full range of mandated and optional home health services.

C. ADMINISTRATION/MANAGEMENT (including organization, staffing, functions)

Voluntary, not-for-profit corporation with a Board of Directors composed of representatives of all participating hospitals and home aide agency. Care to be delivered by "teams" within areas, with a nurse assigned to each hospital to facilitate early discharges.

D. CLINICAL

Services available include: nursing; home health aides; MSS; Medical Supplies and Equipment; Nutrition; Occupational Therapy; Physical Therapy; Speech Pathology; and Respiratory Therapy.

E. FINANCIAL AND REIMBURSEMENT

As Certified CHHA, reimbursement available through Medicare, Medicaid, Blue Cross, Commercial Insurance, Private Pay, Charity Care of 2% projected. Member hospitals will fund start-up costs and early deficits. Self-sufficient following third year.

F. SHARED SERVICES/LINKS

°Participating hospitals will provide physical/speech/occupational therapists and MSS.

°Participating aide agency - contract for home health aides.

G. GENERAL INFORMATION (overall assessment including results, strengths/successes, weaknesses/problems in the system)

°Project not currently operational - evaluation of program, therefore, not possible.

°Concept offers several advantages

-Financially can offer wider variey of services than if individuals developed separate programs.

-Spirit of cooperation in this endeavor may have future benefits.

COLUMBIA-GREENE COUNTY ADOLESCENT PREGNANCY PREVENTION SERVICES

Contact Person:
Donna Bird
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Northeastern New York
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A. WHY WAS THE PROGRAM UNDERTAKEN?

The program was initiated in 1984 by the Columbia County Youth Bureau and the Teen-Parent Program of Columbia Opportunities Inc., in response to a recognized community need and to the availability of funding through Governor Cuomo's Comprehensive Statewide Adolescent Pregnancy Initiative.

B. GENERAL DESCRIPTION (including components, service area and clients)

The program provides a variety of services related to health care, counseling, advocacy, education, employment, childcare, transportation, and housing to teens at risk of becoming pregnant, pregnant and parenting teens, and their families in Columbia and Greene Counties. Four agencies--the Columbia County Teen Parent Program, Greene County's Young Parents Assistance Program, Catholic Family and Community Services, and Capital Area Health Plan--all receive funding to provide services under the program. Other services are provided by agreement with approximately twenty agencies in the two counties. Representatives of these agencies sit on an advisory council which meets bimonthly to renew performance indicators and propose program improvements.

C. ADMINISTRATION/MANAGEMENT (including organization, staffing, functions)

Columbia Opportunities, Inc., which sponsors the Teen Parent Program, acts as lead agency for the project, and is responsible for managing grant funds, collecting utilization data, and coordinating program activities. Representatives of the funded agencies meet biweekly for program and case management review. Some training and evaluation services are provided by the State Department of Social Services and outside consultants.

D. CLINICAL

Direct health care services are provided to APPSP clients at the Hudson office of Capital Area Community Health Plan, which has developed a special adolescent health care unit in response to community needs. A family practice physician and a nurse practitioner with OB/GYN training provide the care.

E. FINANCIAL AND REIMBURSEMENT

APPSP receives a $200,000 a year grant from the New York State Department of Social Services for its programs. This money covers some administrative costs, but is primarily intended to subsidize the cost of direct services to the program's clients.

F. SHARED SERVICES/LINKS

APPSP has linkage with approximately twenty agencies, including local hospitals and family planning clinics, county departments of social services, youth bureaus, public health agencies, Cooperative Extension, BOCES, and a number of schools and churches.

G. GENERAL INFORMATION (overall assessment including results, strengths/successes, weaknesses/problems in the system)

Now entering into its second year, the APPSP program is fine-tuning its system. Among the problems that need to be addressed are lack of childcare, limits on services to teens not at risk, case management and utilization reporting. The APPSP Advisory Council has just become formally organized, and its role in the project is still not clear. Funding for the second year of the project has been held to first year levels, and providers are looking to other sources to pick up identified shortfalls. Concerns are already beginning to surface about long-term support for the program, since the DSS grant has a three-year duration and many of the services provided by APPSP are not reimbursable.

HUDSON HEADWATERS HEALTH NETWORK/UPPER HUDSON PRIMARY CARE CONSORTIUM

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Northeastern New York
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A. WHY WAS THE PROGRAM UNDERTAKEN?

Hudson Headwaters Health Network was undertaken in 1978 by Dr. John Rugge and Glens Falls Hospital to address primary care needs in rural Warren County. The Consortium began in 1985 as a way to strengthen HHHN, Benedict Community Health Center, and Adirondack Regional Hospital. Current Consortium members believe that, by pooling certain organizational resources, they are able to improve their ability to meet community needs.

B. GENERAL DESCRIPTION (including components, service area and clients)

At the present time, HHHN operates five primary care satellites in Warren and Hamilton counties which serve about 23,000 people. Benedict Community Health Center, located in central Saratoga County, experienced over 8,000 patient visits in 1986, of which over half were from Medicaid recipients or medically indigent persons. Adirondack Regional Hospital, in northern Saratoga County, opened its primary care center in December 1986, and is now applying to establish it as a diagnostic and treatment center under its own board of directors.

The Consortium is engaged in such activities as recruiting and hiring physicians and physician extenders, developing a common data base for health center utilization, purchasing certain goods and services on behalf of its members, and assisting in the establishment of additional services, as needed.

C. ADMINISTRATION/MANAGEMENT (including organization, staffing, functions)

Dr. John Rugge, who founded HHHN, is still its Executive Director. His administrative staff provide technical assistance to other Consortium members. These retain autonomous boards of directors and management staff. Management and board members from all three participating organizations sit on the Consortium board.

D. CLINICAL

One of the primary functions of the Consortium has been the recruitment of physicians for participating organizations. As the Consortium develops, it is moving toward an organizational model which shows the Consortium as direct employer of physicians, who then work for member facilities under contractual arrangements. Consortium members also employ physician extenders and such supporting professionals as health educators and nutritionists.

E. FINANCIAL AND REIMBURSEMENT

As a Section 330 Community Health Center, HHHN still receives a substantial, albeit declining, portion of its revenues from Federal grants. All members of the Consortium have benefitted from State funding including Primary Ambulatory Care Program and Prenatal Care and Nutrition Program grants. As Article 28 facilities, Consortium members are all receiving clinic rate reimbursement for Medicaid clients.

The Consortium has applied for funds under the Rural Health Services Network Development Program to enable it to take its next steps.

F. SHARED SERVICES/LINKS

Hudson Headwaters Health Network and the Upper Hudson Primary Care Consortium are linked at several levels to North Care, a Glens Falls-based individual Practice Association, and to CompreCare, a prepaid health services plan for Medicaid clients. Through these HMO programs, services of the Consortium are now becoming available in Hamilton, Essex, Saratoga, Warren and Washington Counties. Patients at the primary care centers are referred for acute care services to local hospitals whenever possible. Consortium members have cultivated positive working relationships with local emergency squads.

G. GENERAL INFORMATION (overall assessment including results, strengths/successes, weaknesses/problems in the system)

This program and its various components have experienced phenomenal growth over the last few years. This growth has indeed made primary care more accessible to a large rural population. Further expansion is proposed: Benedict has undertaken major building renovations, Adirondack Regional is looking into an extension clinic site in Greenfield Center, and the Consortium is proposing clinics for Glens Falls and Whitehall. Much of this growth has occurred because the administrative staff of the various programs has been devoted to their success, working long hours and at peak performance levels toward that goal. As the program's growth begins to level off in the next few years, it will be necessary to expand staffing in order to provide adequate coverage for the services (both administrative and clinical) that are advertised.

COMMUNITY ALTERNATIVE SERVICE AGENCY (CASA)

Contact Person:
Timothy A. Gleason
Health Systems Agency of
Western New York
(716)876-7131

A. WHY WAS THE PROGRAM UNDERTAKEN?

To address the problem of increasing costs of long term care services, to emphasize community-based services for the elderly as alternatives to institutionalization, avoid duplication of services, and match individual client needs to appropriate levels of service.

B. GENERAL DESCRIPTION (including; components, service area and clients)

Program: Community Alternative Services of Allegany (CASA)
Service Area: Allegany County
Clients: Elderly Medicaid and Non-Medicaid Individuals
Coordinator: Alan Keohane, (716) 268-9390

C. ADMINISTRATION/MANAGEMENT (including; organization, staffing, functions)

The administration/management of the program is the key element that sets this program apart from other similar systems throughout the State. The program is a joint venture of the Allegany County Office for the Aging, Allegany County Dept. of Health, County Office of Mental Health and County Dept. of Social Services. Each participating entity provides funds to pay for a program coordinator, and provides staff as needed.

D. CLINICAL

CASA coordinates the assessment, screening and placement of all eligible clients. Assessments are done in whatever setting is required. Follow-up is also provided through case management services.

E. FINANCIAL AND REIMBURSEMENT

This program is also unique in that it receives no State funding. The Program Coordinator is funded through contributions from each of the four participating organizations. Other financial support is provided by those organizations through shared staff and in-kind support.

F. SHARED SERVICES/LINKS

As noted in (C.) above, shared services and staff is provided by the four participating county offices. There are also transfer and affiliation agreements in effect between the CASA program and hospitals, nursing homes and home care agencies in the county. This participation of all long term care providers in the County is also an innovative part of the program.

G. GENERAL INFORMATION (overall assessment including; results, strengths/successes, weaknesses/problems in the system)

The statistics and reports maintained by the program show remarkable success and a continued need. A significant cost savings can be documented as well as an improvement in placement practices of elderly residents of Allegany County.

MEETING DENTAL & PRIMARY CARE NEEDS IN ALLEGANY COUNTY

Contact Person:
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A. WHY WAS THE PROGRAM UNDERTAKEN?

To address the need for dental services and primary medical care at a reasonable cost in a medicall underserved area with a significantly high proportion of Medicaid and financially indigent.

B. GENERAL DESCRIPTION (including; components, service area and clients)

Program: Andover Dental Center and Amity Medical Center
Service Area: Allegany County
Clients: Any person in need of dental or primary care services: particular emphasis on the Medicaid and poor populations of the county.

C. ADMINISTRATION/MANAGEMENT (including; organization, staffing, functions)

The Center is operated through one Administrative structure. The Center utilizes its affiliation agreements with area universities to attract practicing. skilled professionals to Allegany County on a time-share basis. This time-shared approach is what makes this program an innovative strategy in this rural area.

D. CLINICAL

Quality dental and primary care services can be provided in an area that has had problems in recruiting and maintaining these professionals. Through the time-share approach. a full range of specialists in each field can be brought into the Center on an "as-needed" basis.

E. FINANCIAL AND REIMBURSEMENT

F. SHARED SERVICES/LINKS

Through utilization of the time-share approach. the Center can link highly skilled professionals from major metropolitan areas (Buffalo. Rochester) to provide quality care in Allegany County at a reasonable cost. This is also achieved through strong affiliation with the University Medical Schools in the region.

G. GENERAL INFORMATION (overall assessment including; results, strengths/successes, weaknesses/problems in the system)

The unique approach of this Center in attracting highly skilled dental and primary care professionals to Allegany County has been very successful. There is indication of avoiding the problem of recruitment and retention of staff by using the time-share approach. Continuity of care is also enhanced. The sponsor has indicated that the Center has opened up avenues that have not existed before in their area.

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STATE OF NEW YORK

LEGISLATIVE COMMISSION ON RURAL RESOURCES

The Commission on Rural Resources was established by Chapter 428 of the Laws of 1982, and began its work February, 1983. A bipartisan Commission consisting of ten state legislators from the Senate and Assembly, its primary purpose is to promote a state-level focus and avenue for rural affairs policy and program development in New York State. The Commission seeks to pool different knowledges and skills, to narrow areas of controversy, and to broaden areas of agreement. It is believed the enhancement of rural quality of life and institutions will lead to a healthier, more prosperous state.

The Commission provides policymakers with a unique capability and perspective from which to anticipate and approach large-scale problems and opportunities in the state's rural areas. In addition, legislators who live in rural New York are in the minority, with 31 out of 211 members. They look to the Commission for assistance in fulfilling their responsibilities to constituents, primarily in the areas of policy and program development, problem solving, legislative oversight, and funding.

The Commission seeks to amplify the efforts of others who are interested in such policy areas as human services and community life; health care; education; business, economic development, and employment; agriculture; environment, land use, and natural resources; transportation; community facilities, housing, and community renewal; and government and management. Clearly, the state's most vital rural resource is its human capital.

The Commission believes that the tendency to break up into narrow pressure groups can be a grave, disintegrating force in state policy and program development for rural New York. The number one challenge is to get diverse groups to work together, and to combine their efforts to the end that the people of this state may always have the highest possible quality of life, cultural, and material standards of living, without sacrificing their freedom. It is believed that only through joint democratic efforts can policy and programs be devised and administered for the state's rural areas which support and sustain each other in the public interest.

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